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

	ATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIP. D PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDIN 155064 B. WING		UILDING	IPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED 08/23/2022	
	PROVIDER OR SUPPLIEF			3518 S	ADDRESS, CITY, STATE, ZIP COD LAFOUNTAIN ST MO, IN 46902		
	TOAKE KOKOWO			KOKOK	WO, IIV 40302		1
(X4) ID PREFIX		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 APPROPR	IATE	(X5) COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
E 0000							
Bldg			E 0	000	This Plan of Correction is the center's credible allegation o compliance.  Preparation and/or execution	f n of	
	Facility Number: 000025 Provider Number: 155064 AIM Number: 100274850  At this Emergency Preparedness survey, Aperion Care Kokomo was found in substantial compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73.  The facility has 105 certified beds. At the time of the survey, the census was 57.  Quality Review completed on 08/29/22				this plan of correction does not constitute admission or agree by the provider of the truth of facts alleged or conclusions forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.	ement f the set	
E 0004 SS=C Bldg	484.102(a), 485.6 485.727(a), 485.9 491.12(a), 494.62 Develop EP Plan, Annually §403.748(a), §416 §441.184(a), §466 §483.73(a), §483. §485.68(a), §485. §485.920(a), §486 §494.62(a).	5(a), 483.475(a), 483.73(a), 25(a), 485.68(a), 20(a), 486.360(a), (a) Review and Update 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),					
	The [facility] must	comply with all applicable					
LABORATO	RY DIRECTOR'S OR PRO	VIDER/SUPPLIER REPRESENTATIVE'S SI	IGNATUR	E	TITLE		(X6) DATE

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

(X6) DATE

Jeff Attinger **RVP** of Operations 02/06/2023

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

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	OF CORRECTION			COMPLETED 08/23/2022	
	PROVIDER OR SUPPLIER		351	EET ADDRESS, CITY, STATE, ZIP COD 8 S LAFOUNTAIN ST KOMO, IN 46902	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFI TAG	CROSS-REFERENCED TO THE APPROPRI	(X5) COMPLETION DATE
TAG	Federal, State and preparedness req must develop estate comprehensive er program that mee section. The emer program must include the following elem (a) Emergency Pladevelop and main preparedness planand updated at leamust do all of the * [For hospitals at §485.625(a):] Emergency Planate develop and main preparedness req CAH] must comprehensive er program that mee section, utilizing at * [For LTC Facilitie Emergency Planate develop and main preparedness planand updated at lease * [For ESRD Facil Emergency Planate develop	d local emergency uirements. The [facility] ablish and maintain a mergency preparedness ts the requirements of this gency preparedness ude, but not be limited to, ents:  an. The [facility] must tain an emergency in that must be [reviewed], east every 2 years. The plan following:  §482.15 and CAHs at ergency Plan. The [hospital haply with all applicable d local emergency uirements. The [hospital or op and maintain a mergency preparedness ts 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,	TAG	DEFICIENCY)	DATE
	· ·	n that must be [evaluated],			
		view and interview, the facility d maintain an emergency	E 0004	I. What corrective action(s) will be accomplished	10/04/2022 d for

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155064	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 08/23/2022
	ROVIDER OR SUPPLIER		3518 S	ADDRESS, CITY, STATE, ZIP COD S LAFOUNTAIN ST MO, IN 46902	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY 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 APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
TAG	preparedness plan t at least annually in 483.73(a). This definition occupants.  Findings include:  Based on review of Preparedness Plan of to 10:36 a.m., docu emergency program the most recent twe available for review plan available has repast 12 months with date being listed as interview at the time. Administrator state been reviewed, but showed a small parand no review date Emergency plan its with the facility Reyadministrator-in-Trunding processor.	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 f 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	TAG	those residents found to have been affected by the deficient practice; No residents were affected by alleged deficient practice  II. How other resident having the potential to be affected by the same deficient practice be identified and what correct 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 revore the emergency plan was a to the QAPI calendar every 1 months.  IV. How the corrective action(s) will be monitored to ensure the deficient practice not recur i.e., what quality assurance program will be puplace; The admin or designee will retain the QAPI calendar monthly a also check the date of the last update of the emergency	et t y this  ts ected e will tive ial to  m  Il be emic ure es not ne view dded 2  will  ut into
				preparedness plan to ensure	it is

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	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA			ONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155064	B. WING 08/23/2022				
	PROVIDER OR SUPPLIER	2		3518 S	ADDRESS, CITY, STATE, ZIP COD LAFOUNTAIN ST MO, IN 46902		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR		(X5) COMPLETION
E 0013 SS=C Bldg	403.748(b), 416.5 441.184(b), 482.1 484.102(b), 485.6 485.727(b), 485.9 491.12(b), 494.62	4(b), 418.113(b), 5(b), 483.475(b), 483.73(b), 25(b), 485.68(b), 20(b), 486.360(b), (b)		TAG	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	onths. ill be ce s or A cends	DATE
	§403.748(b), §416 §441.184(b), §460 §483.73(b), §483. §485.68(b), §485. §485.920(b), §486 §494.62(b). (b) Policies and proper and impless policy on the emergency (a) of this section, paragraph (a)(1) of communication plants	P Policies and Procedures 5.54(b), §418.113(b), 9.84(b), §482.15(b), 475(b), §484.102(b), 625(b), §485.727(b), 6.360(b), §491.12(b), 9.360(b), 9.3					
	years.  *[For LTC facilities and procedures. To develop and impless.)	s at §483.73(b):] Policies The LTC facility must ement emergency cies and procedures, based					

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155064	 UILDING	INSTRUCTION	CON	TE SURVEY  MPLETED  23/2022
	PROVIDER 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 CORRECT (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPRO DEFICIENCY)	BE	(X5) COMPLETION DATE
	(a) of this section, paragraph (a)(1) of communication plasection. The policible reviewed and use "Additional Requires ESRD Facilities:  *[For PACE at §46 procedures. The develop and imples preparedness policing on the emergency (a) of this section, paragraph (a)(1) of communication plasection. The policies and greated disasters likely to safety of the particular the policies and previewed and upded "[For ESRD Faciliar and procedures." develop and imples preparedness policing on the emergency (a) of this section, paragraph (a)(1) of communication plasection. The policies and procedures.	cies and procedures, based plan set forth in paragraph risk assessment at of this section, and the an at paragraph (c) of this sies and procedures must ment 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.				

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155064	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(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 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)	.TE	(X5) COMPLETION DATE
	supply interruption likely to occur in the area.  Based on record reversal failed to develop and preparedness police reviewed and update accordance with 42 practice could affect.  Based on review of Preparedness Plance to 10:36 a.m., document of the available for reviewer most recent twelves available for reviewer plan available has no past 12 months with date being listed as interview at the time. Administrator-in-Trust the plan had been reviewed at the actual Emergence with the President, the Admin Maintenance Direct	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 at the emergency preparedness of been reviewed within the at 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 the nistrator-in-Training, and the or at 3:50 p.m., no additional tence could be provided	E 00	013	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 resident having the potential to be affe by the same deficient practice be identified and what correct 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 an updated.  III. What measures will put into place and what syster changes will be made to ensure that the deficient practice doe recur; The IDT was inserviced on the emergency management requirements. A review and upof the emergency preparedne policies and procedures was added to the QAPI calendar end 12 months.	this  s cted will ive al to ency d  be mic re s not e	10/05/2022

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CENTERS FOR MEDICARE & MEDICAID SERVICES							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			(X3) DATE SURVEY COMPLETED 08/23/2022	
NAME OF PROVIDER OR SUPPLIER  APERION CARE KOKOMO  (X4) ID SUMMARY STATEMENT OF DEFICIENCIE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION		STREET ADDRESS, CITY, STATE, ZIP COD 3518 S LAFOUNTAIN ST KOKOMO, IN 46902			•			
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE	
					IV. How the corrective action(s) will be monitored to ensure the deficient practice of not 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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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155064		A. BU	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 08/23/2022	
	PROVIDER OR SUPPLIER	3		3518 S	ADDRESS, CITY, STATE, ZIP COD 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 Eparedness communication		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE	
	plan that complies local laws and mu at least every 2 ye facilities].	s with Federal, State and est be reviewed and updated ears [annually for LTC	F O	029	I What corrective action	(s)	10/04/2022	
	failed to develop ar preparedness comm with Federal, State, with 42 CFR 483.7 could affect all occilional federal fede	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 been reviewed within the past 12 ht documented review date 4/2019. Based on interview at eview, the raining stated that he thought eviewed, but documentation wed a small part of the plan and no review date was added tency plan itself. During the exit of facility Regional Vice inistrator-in-Training, and the tor at 3:50 p.m., no additional	E 00	029	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 has 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 does recur;  The IDT was inservice	ce; ent ving the	10/04/2022	
	contrary to this defi	ence could be provided icient finding.			the emergency preparedness requirements. A complete revior of the emergency plan was act to the QAPI calendar every 12 months.  IV. How the corrective action(s) will be monitored to	lded		

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER		` ′	X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			survey leted /2022	
	ROVIDER OR SUPPLIER	2	3	518 S	DDRESS, 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	PRI	D EFIX AG	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	403.748(d), 416.5 441.184(d), 482.1 484.102(d), 485.6 485.727(d), 494.62 EP Training and T §403.748(d), §416 §441.184(d), §466 §483.73(d), §483. §485.68(d), §485. §485.920(d), §486. §494.62(d). *[For RNCHIs at § 404.62(d). *[For RNCHIs at § 404.62(d). *[August & §418.1 PACE at §460.84, HHAs at §484.102 CAHs at §486.625	4(d), 418.113(d), 5(d), 483.475(d), 483.73(d), 25(d), 485.68(d), 20(d), 486.360(d), (d)			ensure the deficient practice wonot recur i.e., what quality assurance program will be put place;  The admin or designee will review the QAPI calendar more and also check the date of the update of the emergency preparedness plan to ensure it reviewed at least every 12 monormood The results of these audits will reviewed in Quality Assurance Meeting monthly x12 months of 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.	t into  II  Inthly I last I is I be I be I cor  I dele	

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	OF CORRECTION	IDENTIFICATION NUMBER  155064	A. BU	A. BUILDING  B. WING			ETED 2022
	PROVIDER OR SUPPLIER			3518 S I	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)	ΤE	(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.	ng. The [facility] must tain an emergency ning and testing program ne emergency plan set forth					
	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	ssessment 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					

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	T OF HEALTH AND HU R MEDICARE & MEDIC						RM APPROVED IB NO. 0938-039
	TEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION  PLAN OF CORRECTION IDENTIFICATION NUMBER  155064  A. BUILDING  B. WING				ONSTRUCTION	(X3) DATE SURVEY COMPLETED 08/23/2022	
	PROVIDER OR SUPPLIEIN CARE KOKOMO	3		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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	Training, testing, dialysis facility must emergency prepared and patient orient on the emergency (a) of this section, paragraph (a)(1) of procedures at parand the community of this section. The orientation program updated at every Based on record regalled to develop are preparedness training was reviewed and accordance with 42 practice could affect.  Findings include:  Based on review of Preparedness Plands to 10:36 a.m., docut training program regard the most recent two available for review plan available has repast 12 months with date being listed as interview at the time Administrator-in-T	wiew and interview, the facility and maintain an emergency and testing program that updated at least annually in CFR 483.73(d). This deficient	E 00	036	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 has 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	ce; ent ving the	10/04/2022

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presented only showed a small part of the plan had been reviewed and no review date was added

conference with the facility Regional Vice

to the actual Emergency plan itself. During the exit

President, the Administrator-in-Training, and the

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What measures will be put

into place and what systemic

changes will be made to ensure

that the deficient practice does not

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155064	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 08/23/2022
	ROVIDER OR SUPPLIER		3518 S	ADDRESS, CITY, STATE, ZIP COD B 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 APPROPRI 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 revof the emergency plan was a to the QAPI calendar every 1 months.  IV. How the corrective action(s) will be monitored to ensure the deficient practice not recur i.e., what quality assurance program will be puplace;  The admin or designee we review the QAPI calendar monand also check the date of the update of the emergency preparedness plan to ensure reviewed at least every 12 m. The results of these audits we 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 troor patterns and make recommendations to revise the plan of correction as indicate.	will  will  will  onthly e last  it is onths. ill be ee or
K 0000					
Bldg. 01	Licensure Survey w	Recertification and State vas 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 n	f of

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STATEMENT OF DEFICIENCIES X1) 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 SHOULD CROSS-REFERENCED TO THE APPRODE DEFICIENCY)	OBE 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 again by 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 es set //or
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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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>01</u> COMPLE			ETED	
		155064	B. WI	NG		08/23/	2022
				CTREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	ROVIDER OR SUPPLIER	1					
ADEDIO	LOADE KOKOMO			3518 S LAFOUNTAIN ST KOKOMO, IN 46902			
APERIO	N CARE KOKOMO			KOKON	MO, IN 46902		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DROVIDED'S DI 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'	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	16	DATE
	Based on observation	on and interview, the facility	K 02	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	,	
	open the door leaf with not more than one				potential to be affected by this		
	-	This deficient practice could			alleged deficient practice.		
	affect all staff in the	-			agod doo.n. praotioo.		
					II. How other residents ha	vina	
	Findings include:				the potential to be affected by	-	
	i mumgs meruuer				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		
		dding 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		
		ged the kitchen door to the			all doors were completed to	101	
		having an independent dead			ensure on doors that need to be	20	
	-	or handle with a latching			locked, there was only one loc		
		ed that he would fix the issue			mechanism.	Kirig	
		find the time to do so. During			mechanism.		
		with the facility Regional Vice					
		inistrator-in-Training, and the			) A/b at magazinas wii	ıı	
		_			I. What measures will	l <b>l</b>	
		for 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 ensi	ure	
					one is not already in place.		
					IV. How the corrective		
					action(s) will be monitored to		

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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	<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 N. A.V. OF 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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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPLI	ETED
		155064	B. W	ING		08/23/2	2022
		<u> </u>		CTREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIE	R			LAFOUNTAIN ST		
∧DEDI∩I	N CARE KOKOMO				MO, IN 46902		
AFERIO	N CARE ROROWO			KOKOK	WO, IN 40902		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE .	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	in. (1525 mm.)				II. How other residents ha	aving	
	(b) The health care occupancy fire safety plan and				the potential to be affected by	the	
	training program address 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				alleged deficient practice. Who	eels	
	_	ncy equipment not in use			were added to the identified P		
		transport equipment			containers. The scale was mo	ved	
	_	tice could affect approximately			out of the corridor.		
	12 residents, 2 staff and 1 visitor.						
	Findings include:				III. What measures will be	put	
					into place and what systemic		
		ons made during a tour of the			changes will be made to ensu		
	1	enance Director and the			that the deficient practice does	s not	
		Fraining on 08/23/22 at 1:40			recur;		
	_	nall plastic 3-drawer chest			The nursing and		
		outside resident room #301.			housekeeping staff were inser	viced	
		t contained P.P.E. for staff, and			on maintaining a free,		
		ls. Based on interview with the			unobstructed corridor in case		
		tor at the time of the			emergency. The maintenance		
		nowledged the 3-drawer chest			director or designee will comp		
	_	he corridor and agreed that it			walking rounds 5 days a week	( to	
		During the exit conference			ensure the corridors remain		
	1	gional Vice President, the			unobstructed and record the		
		raining, and the Maintenance			results on the preventative		
	_	n., no additional information or			maintenance log.		
		provided contrary to this			l		
	deficient finding.				I. How the corrective	;	
	2.1.10(1)				action(s) will be monitored to		
	3.1-19(b)				ensure the deficient practice v	VIII	
					not recur i.e., what quality		
	2) Based on observation and interview, the facility				assurance program will be put	i into	
	failed to ensure 1 of 5 means of egress were				place;		
	1	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 approx	simately 12 residents, 2 staff			ensure the corridors remain	l	

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155064	r í	JILDING	nstruction  01	(X3) DATE : COMPL 08/23/	ETED
	PROVIDER OR SUPPLIER			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 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 no 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 tion, 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 ximonths or until an average of compliance or greater is achied 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 s using one of the following angements:  S OR SECURITY THREAT king arrangements for the leds of the patient are king device shall be					

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155064	A. B	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 08/23/2022	
	PROVIDER OR SUPPLIEIN CARE KOKOMO		•	3518 S	NDDRESS, CITY, STATE, ZIP COD LAFOUNTAIN ST 10, IN 46902		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	DATE
1710		n door and provisions shall		1110			BITTE
	l ·	apid removal of occupants					
		l of locks; keying of all					
	locks or keys carried by staff at all times; or						
	1	e 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						
	Where special locking arrangements for the						
	safety needs of th						
	the Clinical or Security Locking requirements						
	are being met. In addition, the locks must be						
	electrical locks that fail safely so as to						
	release upon loss	of power to the device; the					
	building is protect	ed by a supervised					
	automatic sprinkle	er system and the locked					
	1 '	d by a complete smoke					
	1	(or is constantly monitored					
		cation within the locked					
		the sprinkler and detection					
		nged to unlock the doors					
	upon activation.						
	18.2.2.2.5.2, 19.2						
	DELAYED-EGRE						
	ARRANGEMENT						
		delayed-egress locking					
	1 -	in accordance with					
		permitted on door					
		ng low and ordinary hazard					
		ngs protected throughout by					
		ervised automatic fire or an approved, supervised					
	automatic sprinkle						
	18.2.2.2.4, 19.2.2						
	· ·	.2.4 ROLLED EGRESS					
	LOCKING ARRAI						
		d Egress Door assemblies					
		dance with 7.2.1.6.2 shall					

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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	LETED
		155064	B. WI	NG	_	08/23	/2022
			1	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER	8			LAFOUNTAIN ST		
APERION	N CARE KOKOMO			l	MO, IN 46902		
(X4) ID	SUMMARY	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	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	be permitted.	0.4					
	18.2.2.2.4, 19.2.2						
		BY EXIT ACCESS					
	LOCKING ARRAN						
		it access door locking in					
		7.2.1.6.3 shall be permitted es in buildings protected					
		approved, supervised					
		approved, supervised ection system and an					
		ised automatic sprinkler					
	system.	ised automatic sprinker					
	18.2.2.2.4, 19.2.2	2.4					
	Based on observation and interview, the facility		K 0	222			10/04/2022
	failed to ensure the means of egress through 1 of		110		I. What corrective action	(s)	10/01/2022
		accessible for residents without			will be accomplished for those		
	-	requiring specialized security			residents found to have been		
	_	ithin a required means of			affected by the deficient practi	ce;	
	egress shall not be	equipped with a latch or lock			No residents were		
	that requires the use	e of a tool or key from the			affected by this alleged deficie	ent	
	egress side unless o	therwise permitted by LSC			practice.		
	19.2.2.2.4. Door-loo	cking arrangements shall be					
	permitted in accord	ance with 19.2.2.2.5.2. This			II. How other residents ha	ving	
	deficient practice co	ould affect over 12 residents, 2			the potential to be affected by	the	
		eeding to exit the facility in an			same deficient practice will be	!	
	emergency situation	n.			identified and what corrective		
					action(s) will be taken;		
	Findings include:				12 residents had the		
					potential to be affected by this		
		ons made during a tour of the			alleged deficient practice. The	!	
	· ·	enance Director and the			code was posted nest to the		
		raining on 08/23/22 at 1:40 p.m.,			keypad for door near resident		
		ent room #129 on Harmony Hall			room #129		
		cility exit, was magnetically			] ,		
		be opened by entering a			III. What measures will be	put	
	-	the code was not posted at the			into place and what systemic		
		rator-in-Training stated that the			changes will be made to ensu		
		d by the door to prevent			that the deficient practice does	s not	
	_	ing, but after a short			recur;	-4	
		rstood the necessity for the			The maintenance direct		
	COMP IN HE MOSIEM TO				I WILL CHACK INFORM CORO NIGON		

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	OF CORRECTION	IDENTIFICATION NUMBER  155064	A. BUILDING B. WING	01	COMPLETED  08/23/2022
	PROVIDER OR SUPPLIER		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
	Regional Vice Presi Administrator-in-Tr Director at 3:50 p.m	ference with the facility dent, the raining, and the Maintenance a., no additional information or rovided contrary to this		on all exit doors without a delategress weekly to ensure they remain in place and record the results on the preventative maintenance log.	
	3.1-19(b)			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 or designee will audit the door conceptate program to the door conceptate with the door with the	ved QA nds
K 0321 SS=E Bldg. 01	barrier having 1-he (with 3/4 hour fire automatic fire extinaccordance 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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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155064		(X2) MULTIPLE CO A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/23/2022		
	PROVIDER OR SUPPLIER		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
	nonrated or field-ado not exceed 48 the door. Describe the floor hazardous areas to REMARKS. 19.3.2.1, 19.3.5.9  Area Separation a. Boiler and Fuel-b. Laundries (large c. Repair, Mainter d. Soiled Linen Rogallons) e. Trash Collection (exceeding 64 gal f. Combustible Sto (over 50 square feg. 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 dool latch into the door frould affect  Findings include:  Based on observation facility with Mainter Administrator-in-Truthe corridor door to Dogwood Room", a	lons) orage Rooms/Spaces eet) classified as Severe	K 0321	I. What corrective action will be accomplished for those residents found to have been affected by the 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;  All residents have the potential to be affected by this alleged deficient practice. All doors on rooms considered	ce. ent ving the

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155064	ì í	JILDING	onstruction 01	(X3) DATE S COMPLI 08/23/2	ETED	
	PROVIDER 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 R LSC 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	
	over 200 boxes of a approximately 400 approximately 20 for interview at the tim Maintenance Direct hazardous and state self-closing device storage to another a he could. During the facility Regional Vadministrator-in-Tubirector at 3:50 p.m.	t. This room contained well ssorted P.P.E. and was square feet in size or set by 20 feet. Based on an e of the observation, the for agreed that the room was detailed to the door or move the appropriate location as soon as exit conference with the fice President, the raining, and the Maintenance in., no additional information or provided contrary to this			hazardous areas were audited a self-closing device. a self-clo device was added to the Dogw storage room.  III. What measures will be into place and what systemic changes will be made to ensurthat 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 of until an average of 90% 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.	put re s not a the ved QA nds		
K 0345 SS=F Bldg. 01	NFPA 101 Fire Alarm Systen Maintenance Fire Alarm Systen							

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R0LA21

Facility ID: 000025

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>01</u> COMPL			LETED
		155064	B. W	NG		08/23/2022	
				STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIEF	8		l	LAFOUNTAIN ST		
APERIO	N CARE KOKOMO			l	MO, IN 46902		
(X4) ID	CIMMADV	STATEMENT OF DEFICIENCIE	1	ID	<u> </u>		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	DATE
1110	Maintenance	Case in an in the second secon					Bille
		m is tested and maintained					
		h an approved program					
	complying with the requirements of NFPA 70,						
		Code, and NFPA 72,					
		m and Signaling Code.					
		n acceptance, maintenance					
	and testing are re						
	9.6.1.3, 9.6.1.5, N	FPA 70, NFPA 72					
	Based on record rev	view and interview, the facility	K 0	345			10/04/2022
	failed to ensure 1 of	f 1 fire alarm systems was			I. What corrective action	(s)	
	maintained in accor	dance with LSC 9.6.1.3. LSC			will be accomplished for those	;	
	_	re alarm system to be installed,			residents found to have been		
		ned in accordance with NFPA			affected by the deficient practi	ce;	
		cal Code and NFPA 72,			No residents were		
		n Code. NFPA 72, Section 14.4.5			affected by tis alleged deficien	ıt	
		vise permitted by other			practice		
		le, testing shall be performed					
		the schedules in Table 14.4.5,			II. How other residents ha	_	
	_	uired by the authority having			the potential to be affected by		
	_	72, Section 14.4.5.3.1 states			same deficient practice will be		
		sitivity shall be checked within			identified and what corrective		
	_	tion. NFPA 72, 14.4.5.3.2 states			action(s) will be taken;		
		sitivity shall be checked every			All residents had the		
	-	after unless otherwise			potential to be affected by this		
		iance with Section 14.4.5.3.3. ice could affect all occupants.			alleged deficient practice.		
	This deficient pract	ice could affect an occupants.			III. What measures will be	nut	
	Findings include:				into place and what systemic	put	
	i manigs meiaae.				changes will be made to ensur	r <u>o</u>	
	Based on record rev	view with Maintenance			that the deficient practice does		
		Iministrator-in-Training on			recur;	3 1101	
		.m., a current fire alarm			The sensitivity testing		
	_	menting the smoke detector			documentation was obtained		
		nat smoke detector, and the			showing sensitivity was tested	in	
		the device tested alarmed at,			December of 2020 and is	: <del>-</del>	
		or review. Based on interview			scheduled to be completed ag	ain	
	at the time of record	d review, the Maintenance			in December of 2022. Addition		
		lged the aforementioned			copies of all fire suppression		
		I that he would contact the			equipment will be maintained i	in	

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AND PLAN OF CORRECTION IDENTIF		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	SUMMARY S	STATEMENT OF DEFICIENCIE  CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'		(X5) COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION al paperwork. As of the time of	-	TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)  the administrators office.	TE .	DATE
	the exit conference a documentation coul- review. During the Regional Vice Presi Administrator-in-Tr Director at 3:50 p.m	at 3:50 p.m., this d still not be provided for exit conference with the facility			IV. How the corrective action(s) will be monitored to ensure the deficient practice w not 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 that 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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Event ID:

R0LA21

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	ETED
		155064	B. W	NG		08/23	/2022
				CTREET	ADDRESS SITY STATE ZID COD		
NAME OF I	PROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP COD		
ADEDIO	N OADE KOKOMO				LAFOUNTAIN ST		
APERIO	N CARE KOKOMO			KUKUN	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)	16	DATE
	6 square feet and	sprinkler coverage covers					
		t as required by NFPA 13,					
	· ·	illation of Sprinkler					
	Systems.						
	_	, 19.3.5.3, 19.3.5.4,					
	19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1)						
		on and interview, the facility					03/28/2023
		t a complete automatic	1 12 0	JJ 1	I. What corrective action	(s)	03/20/2023
	sprinkler system was provided for 1 of 1 exterior			will be accomplished for those			
overhang. NFPA 13, Standard for Installation of				residents found to have been			
Sprinkler Systems, 2010 Edition, Section 8.15.7.1				affected by the deficient practi	ce.		
	states sprinklers shall be installed under exterior				No residents were	C <del>C</del> ,	
	roofs, canopies, porte-cocheres, balconies, decks,				affected by this deficient pract	ico	
	or similar projections exceeding 4 ft. (1.2 m) in				anected by this delicient pract	ice.	
	width. Section 8.15.7.2 states sprinklers shall be			II How other regidents be	vina		
		section 8.15.7.2 states sprinklers shall be ed to be omitted where the canopies, roofs,			II. How other residents ha	-	
	_	conies, decks, or similar			the potential to be affected by the same deficient practice will be		
	_	structed with materials that are			•		
		limited combustible, or fire			identified and what corrective		
		cient practice could affect at			action(s) will be taken; 15 residents had the		
		staff and 2 visitors using the					
	main entry to the fa	_			potential to be affected by this		
	main entry to the la	emty.			alleged deficient practice. A	ha	
	Eindines includes				complete sprinkler system will		
	Findings include:				added to the exterior overhang	].	
	Događan obsamjetic	ons made during a tour of the			III AA/bat waa aa waa wiil ba	4	
					III. What measures will be	put	
	_	enance Director and the			into place and what systemic		
		raining on 08/23/22 at 1:23 p.m.,			changes will be made to ensur		
		exterior overhang at the main			that the deficient practice does	s not	
		lity was constructed of wood.			recur;		
		ed approximately seven-nine			Before any new		
		e building and was not			construction occurs, it will be		
	_	th. In addition, the underside			reviewed for the need of a spr	ınkler	
		he main entrance was			system.		
		d. Based on interview at the					
		tions, the Maintenance			IV. How the corrective		
	Director agreed that the main entrance overhang				action(s) will be monitored to		
	was constructed of wood, extended more than			ensure the deficient practice will		/ill	
		uilding, and was not sprinkled			not recur i.e., what quality		
	underneath the over	rhang. During the exit			assurance program will be put	into	

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Facility ID: 000025

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER  155064		A. BUILDING B. WING	01	COMPLETED  08/23/2022			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD  3518 S LAFOUNTAIN ST  KOKOMO, 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 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 achied x3 consecutive months. The Committee will identify any tree or patterns and make recommendations to revise the plan of correction as indicated	I be eved 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 test secure location and	Maintenance and Testing Maintenance and Testing and standpipe systems ted, and maintained in IFPA 25, Standard for the g, and Maintaining of Protection Systems. In design, maintenance, ting are maintained in a d readily available. system last checked  system test					
	c) Water system	supply source					
	coverage for any r automatic sprinkle 9.7.5, 9.7.7, 9.7.8, 1) Based on record		K 0353	What corrective action	(s) 10/04/2022		

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Event ID:

R0LA21

Facility ID: 000025

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155064	B. W	ING		08/23/	2022
				CTREET	ADDRESS CITY STATE ZID COD		
NAME OF I	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD LAFOUNTAIN ST		
ADEDIO	N CARE KOKOMO				MO, IN 46902		
APERIO	N CARE KOKOMO			KOKOK	WO, IN 40902		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF 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	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	piping systems was	examined for internal			will be accomplished for those		
	obstructions where	conditions exist that could			residents found to have been		
	cause obstructed pi	ping as required by NFPA 25,			affected by the deficient practi	ce;	
	2011 Edition, the S	tandards for the Inspection,			No residents had the		
	Testing and Mainte	nance of Water-Based Fire			potential to be affected by this		
	Protection Systems	, Section 14.2.1. Section 14.2.1			alleged deficient practice.		
	states, "except as di	iscussed in 14.2.1.1 and					
	14.2.1.4 an inspecti	on of piping and branch line			II. How other residents ha	ving	
	conditions shall be	conducted every 5 years by			the potential to be affected by	the	
	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 f	for the purpose of inspecting			action(s) will be taken;		
	for the presence of	foreign organic and inorganic			All residents had the		
	material. This defic	eient practice affects all			potential to be affected by this		
residents, staff, and visitors.				alleged deficient practice. An			
					inspection of the internal pipes	3,	
	Findings include:				and repair of the fire hydrate will		
					be completed		
	Based on record rev	view with Maintenance					
	Director and the Ad	lministrator-in-Training on			III. What measures will be	put	
	08/23/22 at 1:20 p.i	m., documentation for a current			into place and what systemic		
	5-year internal pipe	investigation for the facility			changes will be made to ensu	re	
		ould not be provided for review.			that the deficient practice does	s not	
	Based on interview	at the time of record review,			recur;		
	the Maintenance Di	irector acknowledged the			The sprinkler system		
		ndition and stated that he			maintenance and testing sche	dule	
		endor for additional			was added to the preventive		
	paperwork. As of the	ne time of the exit conference at			maintenance log and will be		
	3:50 p.m., this docu	amentation could still not be			verified monthly		
	_	v. During the exit conference					
		gional Vice President, the			IV. How the corrective		
		raining, and the Maintenance			action(s) will be monitored to		
	_	n., no additional information or			ensure the deficient practice w	/ill	
	_	provided contrary to this			not recur i.e., what quality		
	deficient finding.				assurance program will be put	into	
					place;		
	3.1-19(b)				The administrator or		
					designee will audit the		
	2) Based on observa	ation and interview, the facility			maintenance log monthly The	.	
	failed to ensure 1 of 1 private fire hydrant was		1		results of these audits will be		

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

AND PLAN OF CORRECTION IDENTIFICATION NUMBER  155064		 JILDING	01	COMPL 08/23/	ETED	
NAME OF P	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD LAFOUNTAIN ST		
APERION	N CARE KOKOMO			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 APPROPRIATE DEFICIENCY)		(X5) COMPLETION 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:  Based on record review with Maintenance Director and the Administrator-in-Training on 08/23/22 at 2:20 p.m., the fire hydrant document entitled 'Fire Hydrant Inspection" dated 09/14/2021 stated that the inspection failed.			reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achier x3 consecutive months. The Committee will identify any treator patterns and make recommendations to revise the plan of correction as indicated.	ved QA nds	
	entitled 'Fire Hydran 09/14/2021 stated the Further review under stated, "Hydrant will "FROZEN" and will Based on an intervied Director at 2:20 p.m. provided to show the repaired, or any action inspection. During the facility Regional Vinder Administrator-in-Tre Director at 3:50 p.m.	nt Inspection" dated nat the inspection failed. or the comments section I not open, the valve is I require excavation to repair." ow with the Maintenance not, no documentation could be the fire hydrant had been on taken as a result of this the exit conference with the				
K 0355 SS=F Bldg. 01	NFPA 101 Portable Fire Extir Portable Fire Extir Portable fire exting installed, inspected	oguishers guishers are selected, d, and maintained in IFPA 10, Standard for				

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Event ID:

R0LA21

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	01	COMPL	ETED
		155064	B. W	ING		08/23/	2022
				CTREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	2					
ADEDIO	A CARE KOKOMO				LAFOUNTAIN ST		
APERIO	N CARE KOKOMO			KUKUI	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	ΓE	COMPLETION
TAG	REGULATORY OF	R 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		
	I -	Section 7.2.1.2 says Fire			residents found to have been		
	extinguishers shall be inspected either manually or				affected by the deficient practi	ce:	
	by means of an electronic device / system at a				No residents were	,	
	minimum of 30-day intervals. This deficient				affected by this alleged deficie	nt	
	practice could affect all residents, staff, and				practice.		
	visitors within the facility.						
					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;		
	Administrator-in-Training on 08/23/22 at 1:00 p.m.,				No residents had the		
		inguisher located immediately			potential to be affected by this		
	_	missions Directors office was			alleged deficient practice. The		
		22 monthly inspection. Further			portable fire extinguishers wer		
		during the continuing tour of			inspected	o un	
		I portable fire extinguishers			l liopostou		
	1	the facility were in fact			III. What measures will be	nut	
		22 monthly inspection. Based			into place and what systemic	put	
		he time of each observation,			changes will be made to ensur	-Δ	
		rector stated that he must			that the deficient practice does		
		forgot to do the monthly			recur;	TIOL	
		uisher inspections in July of			The maintenance direct	tor	
		kit conference with the facility			will audit the portable fire	,101	
	Regional Vice Presi	•			extinguishers week to ensure	hev	
	_	raining, and the Maintenance			are inspected at least monthly	•	
		n., no additional information or			record the results of audit on t		
	_	provided contrary to this			preventive maintenance log.	16	
	deficient finding.	novided contrary to this			preventive maintenance log.		
	deficient infumg.				IV. How the corrective		
	3.1-19(b)				action(s) will be monitored to		
	3.1-17(0)					rill	
					ensure the deficient practice w	'III	
					not recur i.e., what quality	into	
					assurance program will be put	IIIO	
					place;		
					The administrator or		

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Event ID:

R0LA21

Facility ID: 000025

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	OF CORRECTION	IDENTIFICATION NUMBER  155064	A. BUILDING B. WING	01	COMPLETED 08/23/2022
	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)	(X5) COMPLETION DATE
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting of than required encle exits, 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. T apply to auxiliary s flammable or coml Clearance betwee covering is not exc doors complying w if provided with a c the door closed wh applied. There is a closing of the door release when the	orridor openings in other osures of vertical openings, areas resist the passage made of 1 3/4 inch 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 spaces that do not contain		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 Committee will identify any tre or patterns and make recommendations to revise the plan of correction as indicated	ved QA nds

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Event ID:

R0LA21

Facility ID: 000025

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	IPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILD	ING	01	COMPL	
		155064	B. WING		_	08/23	/2022
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 3518 S LAFOUNTAIN ST KOKOMO, IN 46902				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	II	D	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PRE	EFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE.	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TA	AG	DEFICIENCY)		DATE
TAG	unlimited height a meeting 19.3.6.3.0 frames shall be la other materials in unless the smoke sprinklered. Fixed allowed per 8.3. In there are no restri resistance of glass assemblies.  19.3.6.3, 42 CFR 483, and 485 Show in REMARK fire protection ratio devices, etc. Based on observation failed to ensure 9 of doors to the corrido latch into the door frould affect approximates staff and visitors.  Findings include:  Based on observation facility with Mainter Administrator-in-Trans. The domain observation facility with Mainter Administrator-in-Trans. The dose and latch into curtain obstructed to 2) Resident room # latch into the frame 3) Resident room # latch into the frame 4) Resi	re permitted. Dutch doors are permitted. Door beled and made of steel or compliance with 8.3, compartment is fire window assemblies are a sprinklered compartments ctions in area or fire are or frames in window.  Parts 403, 418, 460, 482, as details of doors such as angs, automatics closing and interview, the facility and frame. This deficient practice imately 40 residents, as well as a seminately 40 residents, as well as a following was noted:  162 door failed to fully and the frame because a privacy the corridor door and to close and a followed and followed	K 0363		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 deficient practice will be identified and what corrective action(s) will be taken;  40 residents had the potential to be affected by this deficient practice. All fire rated doors were opened and close ensure they all closed correctl and latched. The doors identified not to close and latch properly. The doors will be adjusted or replaced to ensure they properly close and latch.	ice; ice. aving the d d to dy ied	10/04/2022

CENTERS FOI	R MEDICARE & MEDIC	AID SERVICES				OM	IB NO. 0938-039	
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. Bl	JILDING	01	COMPL	LETED	
		155064	B. W	ING		08/23	/2022	
NAME OF I	PROVIDER OR SUPPLIES  N CARE KOKOMO  SUMMARY  (EACH DEFICIEN  REGULATORY OF  latch into the frame  6) Resident room #  to close and failed t  7) Resident room #  into the frame  8) Resident room #  to close and failed t  9) Resident room #	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		STREET . 3518 S	ADDRESS, CITY, STATE, ZIP COD  LAFOUNTAIN ST  MO, IN 46902  PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRUDEFICIENCY)  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 open and close all fire rate	08/23		
	the Maintenance Diaforementioned conwork on the doors a so. During the exit of Regional Vice Pres. Administrator-in-To Director at 3:50 p.n evidence could be predeficient finding.  3.1-19(b)	ew at the time of observations, irector acknowledged the aditions stating that he would as soon as he had time to do conference with the facility ident, the raining, and the Maintenance a., no additional information or provided contrary to this			doors monthly to ensure they close and latch properly, the results will be documented or preventative maintenance log.  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 administrator or designee will audit the maintenance log monthly to ensure are doors are inspected and repairs are made as need. The results of these audits wireviewed in Quality Assurance Meeting monthly x6 months of until an average of 90% compliance or greater is achieved and the compliance or greater is achieved. The committee will identify any treatment of correction as indicated.	will t into  ed ded. Il be e r eved QA ends		
K 0374 SS=E Bldg. 01	NFPA 101 Subdivision of Bui Barrie	ilding Spaces - Smoke						

FORM CMS-2567(02-99) Previous Versions Obsolete

Barrier Doors

Subdivision of Building Spaces - Smoke

Event ID:

R0LA21

Facility ID: 000025

If continuation sheet

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STATEMENT OF DEFICIENCIES XI) 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		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 R 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
	solid bonded wood construction that in Nonrated protective are permitted. Doe fixed fire window are self-closing or require latching, as in the direction of provides a minimular for swinging or how 19.3.7.6, 19.3.7.8. Based on observation failed to ensure 3 or restrict the movement minutes. LSC, Section barriers to close the minimum clearance which is defined as movement of smoke affects 32 residents visitors.  Findings include:  Based on observation facility with Mainted Administrator-in-Trans. to 2:31 p.m. the 1) the barrier doors failed to fully close coming together to 2) the barrier doors Room" failed to full when coming togets 3) the barrier doors	resists fire for 20 minutes.  We 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 am clear width of 32 inches rizontal doors.  19.3.7.9  In and interview, the facility of 6 sets of barrier doors would and of smoke for at least 20 ion 19.3.7.8 requires that doors hall comply with LSC, Section 8.5.4.1 requires doors in smoke opening leaving only the encessary for proper operation 1/8 inch to restrict the encessary for proper operation 1.78 inch to restrict the encessary for proper operation 1.79 inch to	K 0374	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;  32 residents had the potential to be affected by this alleged deficient practice. All barrier doors were inspected the ensure proper closure. The 3 barrier doors listed on the 256 were the only doors not to cloproperly and were adjusted.  III. What measures will be into place and what systemic changes will be made to ensut that the deficient practice doe recur;	ice; ice; tice. aving the a to ar put re

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If continuation sheet

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	OF CORRECTION	IDENTIFICATION NUMBER  155064	A. BUILDING B. WING	01	COMPLETED 08/23/2022
	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 APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	the Maintenance Diraforementioned con work on the doors a so. During the exit c 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 as 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 who trecur i.e., what quality assurance program will be purplace;  The administrator will audit the maintenance log monto ensure doors are inspected functioning properly.  The results of these audits wireviewed in Quality Assurance Meeting monthly x6 months of until an average of 90% compliance or greater is achieved and the committee will identify any tree or patterns and make recommendations to revise the plan of correction as indicated.	the don slog.  Will tinto southly dand libe e reved QA ends see
K 0741 SS=E Bldg. 01	shall include not le provisions: (1) Smoking shall ward, or compartm liquids, combustibl used or stored and location, and such signs that read NC				

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· ·		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155064	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 08/23/2022	
	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 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
	smoking is prohibited prominently place secondary signs was smoking shall not (3) Smoking by paresponsible shall I (4) The requirement apply where the paresponsible shall I (4) The requirement apply where the paresponsible shall I (5) Ashtrays of not safe design shall I where smoking is (6) Metal contained devices into which shall be readily awas moking is permitted for staff and accordance with 19 ashtrays of noncoment design shall be provisionable provisional practice could affect staff as well as visit in the second promitted for staff and areas were smoking practice could affect staff as well as visit in the second promitted for staff and areas were smoking practice could affect staff as well as visit in the second promitted for staff and areas were smoking practice could affect staff as well as visit in the second promitted for staff as well as visit in the second promitted for staff as well as visit in the second promitted for staff as well as visit in the second promitted for staff as well as visit in the second promitted for staff as well as visit in the second promitted for staff as well as visit in the second promitted for staff as well as visit in the second promitted for staff as well as visit in the second promitted for staff as well as visit in the second promitted for staff as well as visit in the second promitted for staff as well as visit in the second promitted for staff as well as visit in the second promitted for staff as well as visit in the second promitted for staff as well as visit in the second promitted for staff and the second promitted for staff as well as visit in the second promitted for staff as well as visit in the second promitted for staff as well as visit in the second promitted for staff as well as visit in the second promitted for staff as well as visit in the second promitted for staff as well as visit in the second promitted for staff as well as visit in the second promitted for staff as well as visit in the second promitted for staff as well as visit in the second promitt	d at all major entrances, with language that prohibits be required. atients classified as not be prohibited. Into f 18.7.4(3) shall not atient is under direct atient is under direct ancombustible material and be provided in all areas permitted. In some serious with self-closing cover an ashtrays can be emptied atiliable to all areas where sted.  In and interview, the facility f 1 area where smoking was and residents was maintained in an and interview. The facility f 1 area where smoking was and residents was maintained in an areas where and the facility field in all areas where and the facility field in all areas where and the facility are shown in the facility field in all areas where and the facility are shown in the facility of the facility field in all areas where and the facility are shown in the facility are shown in the facility are shown in the facility and the facility are shown in the facility are shown in the facility and the facility are shown in the facility are shown in the facility and the facility are shown in the facility and the facility are shown in the facility and facility are shown in the facility are shown	K 0	741	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 hat the potential to be affected by same deficient practice will be identified and what corrective action(s) will be taken;  All residents that smok have the potential to be affect by this alleged deficient practice. The smoker area was cleaned and the non-approved contain was removed.	ce; ent ving the	10/04/2022

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STATEMENT OF DEFICIENCIES X1) 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				
NAME OF PROVIDER OR SUPPLIER  APERION CARE KOKOMO			STREET ADDRESS, CITY, STATE, ZIP COD 3518 S LAFOUNTAIN ST KOKOMO, IN 46902					
	SUMMARY (EACH DEFICIEN REGULATORY OF the sidewalk in the container was not a with a self-closing of interview at the tim Maintenance Direct approved container	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION designated smoking area. This n approved metal container device on it. Based on e of observation, the for agreed that this was not an and removed it from the area. Is removed prior to my exiting of	3518	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIDEFICIENCY)  III. What measures will be into place and what systemich changes will be made to ensith the deficient practice do recur;  All staff and smoking residents will be inserviced of proper disposal of smoking material. The housekeeping department will audit the smarea daily to ensure no unapproved containers are if and that smoking material a properly disposed of. The rewill be documented on the smoking area inspection audit to the smoking area will be place;  The admin or design will audit the smoking area	ERIATE COMPLETION DATE  De put course sure pes not point place results dit  De will put into pee ee			
				inspection audit weekly to el smoking material are proper disposed of.  The results of these audits verviewed in Quality Assuran Meeting monthly x6 months until an average of 90% compliance or greater is act x3 consecutive months. The Committee will identify any the smoking material are properly and the smoking material are properly as a consecutive months.	vill be ce or nieved e QA			
				or patterns and make recommendations to revise plan of correction as indicate				

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE S			ΓE SURVEY			
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	COMPLETED		
		155064	B. W	NG		08/23/	2022		
				CTREET	ADDRESS CITY STATE ZID COD				
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD  3518 S LAFOUNTAIN ST						
ADEDION	N CARE KOKOMO		KOKOMO, IN 46902						
APERION	I CARE KOKOWO			KOKOK	10, 111 40902				
(X4) ID	SUMMARY S	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	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE		
K 0914	NFPA 101								
SS=F	Electrical Systems	s - Maintenance and							
Bldg. 01	Testing								
	•	s - Maintenance and							
	Testing								
	•	ceptacles at patient bed							
		re deep sedation or general							
		inistered, are tested after							
		replacement or servicing.							
		is performed at intervals							
	-	ented performance data.							
		sted as hospital-grade at							
	•	e tested at intervals not							
		oths. Line isolation monitors							
		are tested at intervals of							
	• •	to 1 month by actuating							
	-	n per 6.3.2.6.3.6, which							
		al and audible alarm. For							
		utomated self-testing, this							
		formed at intervals less							
	-	2 months. LIM circuits are							
	•	2 after any repair or							
	•								
		electric distribution system.							
		tained of required tests and							
	associated repairs								
		oom or area tested, and							
	results.								
	6.3.4 (NFPA 99)		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			affected by the deficient practic	ce;			
		on 6.3.4.1.3 states receptacles			No residents were				
		l-grade, at patient bed			affected by this alleged deficie	nt			
		ations where deep sedation or			practice				
	-	s administered, shall be tested			l				
	at intervals not exce				II. How other residents ha	-			
		on 6.3.3.2, Receptacle Testing			the potential to be affected by				
	in Patient Care Roo	ms requires the physical			same deficient practice will be				

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STATEMENT OF DEFICIENCIES X1) 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			
NAME OF PROVIDER OR SUPPLIER  APERION CARE KOKOMO			STREET ADDRESS, CITY, STATE, ZIP COD  3518 S LAFOUNTAIN ST  KOKOMO, IN 46902				
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD) CROSS-REFERENCED TO THE APPROP	BE COMPLETION		
PREFIX TAG	resultatory of integrity of each recovisual inspection. The grounding circuit in the verified. Correct connections in each confirmed; and reter blade of each electrolocking-type recept 115 gram (4 ounces affect all residents.)  Findings include:  Based on record recovity of the properties of the pro	R LSC IDENTIFYING INFORMATION ceptacle shall be confirmed by the continuity of the a each electrical receptacle shall a polarity of the hot and neutral a electrical receptacle shall be ention force of the grounding ical receptacle (except acles) shall be not less than b). This deficient practice could  wiew with Maintenance dministrator-in-Training on .m., there was receptacle cumentation to test the continuity, or polarity of the otacles available for review, but Conly roughly one-quarter of the to blank. Based on interview at review, the Maintenance he started the test, but must	TAG	identified and what corrective action(s) will be taken; All residents have the potential to be affected by the alleged deficient practice. A outlets were tested as for peand retention with all outlets passing  III. What measures will into place and what system changes will be made to enthat the deficient practice derecur; The maintenance di was inserviced on outlet testing find polarity and retention will be conducted every September March.  IV. How the corrective action(s) will be monitored the ensure the deficient practice not recur i.e., what quality assurance program will be place; The admin will audit receptaretention testing form every October and April to ensure completion. The results of these audits reviewed in Quality Assurance Meeting monthly x6 months until an average of 90% compliance or greater is act x3 consecutive months. The Committee will identify any or patterns and make recommendations to revise	DATE  DATE  DATE  Ve  ne chis All colarity s be put cic assure coes not director sting. for e er and  to e will put into accle ve  will be nce s or chieved ne QA trends		

PRINTED: 03/03/2023

							RM APPROVED IB NO. 0938-039
STATEMENT OF DEFICIENCIES XI AND PLAN OF CORRECTION ID:		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  (X4) ID SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION  SS=E 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		STREET ADDRESS, CITY, STATE, ZIP COD 3518 S LAFOUNTAIN ST KOKOMO, IN 46902		LAFOUNTAIN ST		
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)  plan of correction as indicate		(X5) COMPLETION DATE
K 0920 SS=E Bldg. 01	Electrical Equipment Extens Electrical Equipment Extension Cords Power strips in a used for compon patient-care-related (PCREE) assembled by question the patient care in non-PCREE (e.g. except in long-teddo not use PCRE meet UL 1363A of for non-PCREE in (outside of vicinitation non-patient care other UL standar used with general cords are not used wiring of a structure temporarily are recompletion of the installed and meet 10.2.3.6 (NFPA 5)	patient care vicinity are only ents of movable ded electrical equipment bles that have been delified personnel and meet 10.2.3.6. Power strips in vicinity may not be used for an ear resident rooms that E. Power strips for PCREE or UL 60601-1. Power strips in the patient care rooms by meet UL 1363. In rooms, power strips meet ds. All power strips are all precautions. Extension ed as a substitute for fixed are. Extension cords used emoved immediately upon					

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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

Electrical Code. NFPA 70, 2011 Edition, Article

400.8 requires that, unless specifically permitted,

flexible cords and cables shall not be used as a

substitute for fixed wiring of a structure. This deficient practice affects as many as 12 residents,

be in accordance with NFPA 70, National

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K 0920

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II.

practice

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What corrective action(s)

How other residents having

will be accomplished for those

residents found to have been

affected by the deficient practice;

No residents were

affected by this alleged deficient

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10/04/2022

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		JILDING	01	COMPLETED 08/23/2022		
155064		B. W	NG		08/23/	2022		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 3518 S LAFOUNTAIN ST KOKOMO, IN 46902					
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID			(X5)	
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	T-	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	16	DATE	
	4 staff and 1 visitor.				the potential to be affected by	the		
TAG	4 staff and 1 visitor. Findings include:  Based on observation facility with Mainte Administrator-in-Truthere was a power such an electric receptact station. Based on an observation, the Maacknowledged the uunplugged it, and receptact station.	ons made during a tour of the mance Director and the raining on 08/23/22 at 1:38 p.m., trip in use and dangling from le in the Harmony Hall nurses a interview at the time of the		TAG	DEFICIENCY)	put re s not d age.  vill into ctor ding r ower	DATE	
					x3 consecutive months. The 0 Committee will identify any tre or patterns and make recommendations to revise the	nds e		
	I		1		I plan of correction as indicated			

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		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  01			(X3) DATE SURVEY COMPLETED	
AND PLAN OF CORRECTION		155064	B. WI		<u>01                                    </u>	08/23/	
				GEN DET 1	A PARAGO CITIL OTLATE TIR COR	33723	
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
APERION	N CARE KOKOMO		3518 S LAFOUNTAIN ST KOKOMO, IN 46902				
(X4) ID	SUMMARY S	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	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
K 0923	NFPA 101						
SS=E	Gas Equipment - 0	Cylinder and Container					
Bldg. 01	Storag						
	Gas Equipment - 0	Cylinder and Container					
	Storage						
		jual to 3,000 cubic feet					
	Storage locations	are designed, constructed,					
	and ventilated in a	ccordance with 5.1.3.3.2					
	and 5.1.3.3.3.						
	>300 but <3,000 c						
	Storage locations						
		n 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					
		onstruction having a					
		re protection rating.					
	Less than or equa						
	_	compartment, individual					
	-	for immediate use in					
	· •	with an aggregate volume					
	-	ual to 300 cubic feet are not red in an enclosure.					
	•	handled with precautions					
	as specified in 11.	· · · · · · · · · · · · · · · · · · ·					
	•	gn readable from 5 feet is					
		ate of a cylinder storage					
	_	ign includes the wording as					
		ION: OXIDIZING GAS(ES)					
	STORED WITHIN	` ,					
		d so cylinders are used in					
		y are received from the					
		ylinders are segregated					
		When facility employs					
	-	gral pressure gauge, a					
	•	e considered empty is					
	-	ty cylinders are marked to					

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. B	UILDING	01	COMPL	LETED	
1550		155064	B. WING			08/23/2022		
				CTREET	ADDRESS CITY STATE ZIR COD	<u> </u>		
NAME OF P	ROVIDER OR SUPPLIER	1			ADDRESS, CITY, STATE, ZIP COD			
ADEDION	LOADE KOKOMO		3518 S LAFOUNTAIN ST					
APERIOR	N CARE KOKOMO			KUKUN	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 OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	.12	DATE	
	avoid confusion. C	Cylinders stored in the open						
	are protected from	-						
		.3.3, 11.3.4, 11.6.5 (NFPA						
	99)							
	,	on and interview, the facility	l K O	923			10/04/2022	
		f 2 cylinders of nonflammable	12 0	,_0	I. What corrective action	(s)	10/0//2022	
		en were properly secured from			will be accomplished for those			
		Health Care Facilities Code, 2012			residents found to have been			
	-	3.2 states storage for			affected by the deficient practi	ice:		
		s greater than 8.5 cubic meters			No residents were	,		
	_	less than 85 cubic meters			affected by this alleged deficie	ent .		
		nall comply with 11.3.2.1			practice.			
		JFPA 99, Section 11.3.2.6 states			Praesice:			
	_	er restraints shall comply with			II. How other residents ha	avina		
	-	1.6.2.3(11) states freestanding			the potential to be affected by	-		
		roperly chained or supported			same deficient practice will be			
		stand or cart. This deficient			identified and what corrective			
		t 24 staff and visitors in the			action(s) will be taken;			
	-	storage and transfilling room.			24 residnets have the			
	, ,,,	5			potential to be affected by this	;		
	Findings include:				alleged deficient practice. The			
	J				oxygen tank was returned to t			
	Based on observation	ons made during a tour of the			oxygen room			
		enance Director and the			1.79			
		raining on 08/23/22 at 1:36 p.m.,			III. What measures will be	put		
		en cylinder was standing			into place and what systemic	•		
		of the Harmony Hall nurses			changes will be made to ensu	re		
		fed) room and was not			that the deficient practice does			
	· ·	supported in a proper cylinder			recur;			
		on interview at the time of			The nursing staff were			
	observation, the Ma				inserviced on proper oxygen			
		mall oxygen cylinder was			storage and transfer. The			
		the floor of the Med room			maintenance director will mak	e		
		y chained or supported in a			weekly rounds to ensure oxyg	_		
		nd or cart. He then removed the			is properly stored and transfer			
		der and returned it to the			and will document the results			
		ling room where it belonged.			the preventive maintenance lo			
		s removed prior to exiting of				· 5·		
	the facility.	1			IV. How the corrective			
	,				action(s) will be monitored to			
			1		assori(s) will be informed to		1	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155064	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE COMPL <b>08/23</b> /	LETED		
NAME OF PROVIDER OR SUPPLIER  APERION CARE KOKOMO			STREET ADDRESS, CITY, STATE, ZIP COD 3518 S LAFOUNTAIN ST KOKOMO, IN 46902					
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY 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)  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 tratof 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	vill into  nsfer be ved QA	(X5) COMPLETION DATE		
				recommendations to revise the plan of correction as indicated	_			

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