STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155064	A. BUILDING _____ B. WING _____	R-C 03/31/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE KOKOMO	**3518 S LAFOUNTAIN ST KOKOMO, IN 46902**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS This visit was for a Post Survey Revisit (PSR) to the Investigation of Complaints IN00370923 and IN00371731 completed on February 2, 2022. This visit was in conjunction with the PSR to the Investigation of Complaint IN00370095 completed on January 10, 2022. This visit was in conjunction with the PSR to the Investigation of Complaint IN00372373 completed on February 10, 2022. This visit was in conjunction with the PSR to the Investigation of Complaints IN00373762 and IN00373364 completed on March 4, 2022 Complaint IN00370923 - Corrected. Complaint IN00371731 - Corrected. Complaint IN00370095 - Corrected. Complaint IN00372373 - Corrected. Complaint IN00373762 - Corrected. Complaint IN00373364 - Corrected. Survey date: March 31, 2022 Facility number: 000025 Provider number: 155064 AIM number: 100274850 Census Bed Type: SNF/NF: 60 Total: 60	{F 000}		

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155064	A. BUILDING _____ B. WING _____	R-C 03/31/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE KOKOMO	**3518 S LAFOUNTAIN ST KOKOMO, IN 46902**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	Continued From page 1 Census Payor Type: Medicare: 9 Medicaid: 35 Other: 16 Total: 60 Aperion Care Kokomo was found to be in compliance with 42 CFR Part 483 Subpart B and 410 IAC 16.2-3.1 in regard to the PSR to the Investigation of Complaints IN00370923 and IN00371731. Quality review was completed on April 6, 2022.	{F 000}		