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	08/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aperion Care Kokomo	3518 S Lafountain St Kokomo, IN 46902

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on interview and record review, the facility failed to ensure the resident or resident's representative received notification in writing of the facility's bed hold policy and the reason for the resident's transfer and discharge to the hospital for 1 of 2 residents reviewed for hospitalization. (Resident 36)Findings include:The clinical record for Resident 36 was reviewed on 8/12/25 at 11:59 a.m. The diagnoses included, but were not limited to, hemiplegia and hemiparesis affecting the left side, hypertension, diabetes mellitus, bipolar disorder, morbid obesity, anxiety, insomnia, chronic obstructive pulmonary disease, schizoaffective disorder, dysphagia, heart failure, atrial fibrillation, a history of urinary tract infection, and kidney stones. A nursing progress note, dated 7/14/25 at 12:13 p.m., indicated Resident 36 had an altered level of consciousness and was sent to the emergency room via ambulance.A nursing progress note, dated 7/21/25 at 4:45 p.m., indicated Resident 36 was transported back to the facility from the hospital via ambulance.The clinical record did not include documentation the bed hold policy or the transfer and discharge summary was provided to Resident 36 or the resident's representative. During an interview, on 8/14/25 at 10:30 a.m., the Director of Nursing (DON) indicated there was no documentation the bed hold policy or the transfer and discharge summary was provided to Resident 36 or the resident's representative. A current facility policy, titled Bed Hold Policy Notice, dated 7/14/25 (the resident's transfer date) and received from the DON on 8/13/25 at 2:00 p.m., indicated Resident 36 was unable to sign at time of transfer and no copy was mailed to the representative. 3.1-12(a)(6)(A)(i)3.1-12(a)(6)(A)(ii)3.1-12(a)(6)(A)(iii)

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.

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on interview and record review, the facility failed to ensure a comprehensive care plan was developed related to hypertension, heart failure, and anticoagulation therapy for 1 of 20 residents reviewed for care plans. (Resident 52)Findings include:The clinical record for Resident 50 was reviewed on 8/12/25 at 10:32 a.m. The diagnoses included, but were not limited to, atrial fibrillation, cardiomyopathy, chronic systolic congestive heart failure, hypertension, acute embolism and thrombosis of deep veins, and history of pulmonary embolism. A physician's order, dated 7/8/25, indicated to administer apixaban (an anticoagulant medication) 5 milligrams (mg) by mouth one time daily.The care plans for Resident 50 did not include a care plan for hypertension, heart failure, or the use of anticoagulant medication. During an interview, on 8/13/25 at 1:22 p.m., the Director of Nursing (DON) indicated there were no care plans for hypertension, heart failure, or the use of anticoagulant medication. There should have been care plans in place.A current facility policy, titled Comprehensive Care Plan, dated as last revised 11/17/17 and received from the DON on 8/15/25 at 9:32 a.m., indicated .The facility will develop and implement a comprehensive person-centered care plan for each resident consistent with the resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing and mental and psychosocial needs that are identified in the comprehensive assessment.3.1-35(a)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. Based on interview and record review, the facility failed to ensure a physician's order was followed according to the ordered parameters for 1 of 5 residents reviewed for quality of care. (Resident 50)Findings include: The clinical record for Resident 50 was reviewed on 8/12/25 at 10:32 a.m. The diagnoses included, but were not limited to, atrial fibrillation, cardiomyopathy, chronic systolic congestive heart failure, hypertension, acute embolism and thrombosis of the deep veins, and a history of pulmonary embolism. A physician's order, dated 7/8/25, indicated give metoprolol tartrate (used to treat high blood pressure) by mouth two times a day for hypertension and to hold the medication for a systolic blood pressure of less than 120 or a heart rate of less than 60.A medication administration record (MAR), dated 7/1/25 through 7/31/25, indicated metoprolol was administered outside of the ordered parameters on:a. the morning of 7/25/25 with a systolic blood pressure of 109.b. the evening of 7/11/25 with a systolic blood pressure of 111.c. the evening of 7/14/25 with a systolic blood pressure of 111.d. the evening of 7/15/25 with a systolic blood pressure of 104.e. the evening of 7/18/25 with a systolic blood pressure of 108.f. the evening of 7/23/25 with a systolic blood pressure of 119. A MAR, dated 8/1/25 through 8/31/25, indicated metoprolol was administered outside of the ordered parameters on:a. the evening of 8/6/25 with a systolic blood pressure of 116.A care plan for hypertension or the use of a medication to treat high blood pressure was not located in the clinical record. During an interview, on 8/13/25 at 11:57 a.m., Qualified Medication Aide (QMA) 2 indicated if a resident's vital signs were outside the parameters for a medication, the medication would be held, and the supervising nurse would be informed. QMA 2 indicated a check mark in the box with initials next to the time on the medication administration record indicated the medication was given. A number in the box would mean the medication was held.During an interview, on 8/13/25 at 3:47 p.m., the Director of Nursing (DON) indicated medications should not be given if a resident's vital signs were outside the physician's ordered parameters.A current facility policy, titled Medication Administration General Guidelines, undated and received from the DON on 8/14/25 at 2:00 p.m., indicated .Medications are administered in accordance with written orders of the prescriber.3.1-37(a)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, interview and record review, the facility failed to ensure equipment settings for prescribed oxygen flow rates were include in the clinical record for 4 of 5 residents reviewed for respiratory care. (Resident 52, 40, 34 and 36)Findings include: 1. During an observation, on 8/10/25 at 1:22 p.m., Resident 52 had oxygen per nasal cannula set at a flow rate of 3 and 1/2 liters per minute (L). During an observation, on 8/11/25 at 9:28 a.m., Resident 52 had oxygen per nasal cannula set at a flow rate of 4L. During an observation, on 8/12/25 at 10:12 a.m., Resident 52 had oxygen per nasal cannula set at a flow rate of 4L. During an observation, on 8/14/25 at 10:26 a.m., Resident 52 had oxygen per nasal cannula set at a flow rate of 5L. The clinical record for Resident 52 was reviewed on 8/12/25 at 10:32 a.m. The diagnoses included, but were not limited to, chronic obstructive pulmonary disease, emphysema, osteoarthritis, dementia without behavioral psychotic disturbance, mood disturbance, and anxiety. A care plan, dated 1/17/22, indicated Resident 52 was at risk for altered respiratory status. An intervention, last updated on 2/1/25, indicated the oxygen settings were oxygen via nasal cannula per the physician's order. There was no physician order which included the equipment settings for the prescribed oxygen flow rate for Resident 52. 2. During an observation, on 8/10/25 at 1:58 p.m., Resident 40 had oxygen per nasal cannula set at a flow rate of 2 and 1/2 liters per minute (L). During an observation, on 8/11/25 at 12:12 p.m., Resident 40 had oxygen per nasal cannula set at a flow rate of 2 and 1/2L. During an observation, on 8/15/25 at 9:02 a.m., Resident 40 had oxygen per nasal cannula set at a flow rate of 4L. The clinical record for Resident 40 was reviewed on 8/12/25 at 11:47 a.m. The diagnoses included, but were not limited to, chronic respiratory failure, chronic obstructive pulmonary disorder, anxiety disorder, atrial fibrillation, and major depressive disorder. There was no physician order which included the equipment settings for the prescribed oxygen flow rate for Resident 40. 3. During an observation, on 8/10/25 at 11:45 a.m., Resident 34 had oxygen per nasal cannula set at a flow rate of 2L. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation, on 8/11/25 at 9:30 a.m., Resident 34 had oxygen per nasal cannula set at a flow rate of 2L. During an observation, on 8/12/25 at 9:26 a.m., Resident 34 had oxygen per nasal cannula set at a flow rate of 2L. During an observation, on 8/13/25 at 1:39 p.m., Resident 34 had oxygen per nasal cannula set at a flow rate of 2L. The clinical record for Resident 34 was reviewed on 8/12/25 at 10:36 a.m. The diagnoses included, but were not limited to, bipolar disorder, intermittent explosive disorder, insomnia, anxiety, high blood pressure, hyperlipidemia, borderline personality disorder, persistent mood disorder, iron deficiency anemia, history of liver cancer, and mild intellectual disabilities. There was no physician order which included the equipment settings for the prescribed oxygen flow rate for Resident 34. 4. During an observation, on 8/11/25 at 9:36 a.m., Resident 36 had oxygen per nasal cannula set at a flow rate of 3L. During an observation, on 8/12/25 at 9:27 a.m., Resident 36 had oxygen per nasal cannula set at a flow rate of 3L. During an observation, on 8/13/25 at 11:26 a.m., Resident 36 had oxygen per nasal cannula set at a flow rate of 3L. During an observation, on 8/14/25 at 10:37 a.m., Resident 36 had oxygen per nasal cannula set at a flow rate of 3L. The clinical record for Resident 36 was reviewed on 8/12/25 at 11:59 a.m. The diagnoses included, but were not limited to, hemiplegia and hemiparesis affecting the left side, high blood pressure, diabetes mellitus, morbid obesity, anxiety, chronic obstructive pulmonary disorder, schizoaffective disorder, dysphagia, heart failure, and atrial fibrillation. There was no physician order which included the equipment settings for the prescribed oxygen flow rate for Resident 36. During an interview, on 8/12/25 at 2:39 p.m., the Regional Nurse Consultant indicated a nurse could start oxygen at a flow rate of 2L and titrate as a nursing measure. During an interview, on 8/14/25 at 12:06 p.m., the Director of Nursing (DON) indicated the facility did not have a specific policy for oxygen administration. The medication administration policy was followed. During an interview, on 8/14/2025 at 1:43 p.m., Registered Nurse (RN) 2 indicated a physician's order with liter flow would be needed to indicate where to set a resident's oxygen flow rate. If a liter flow rate was not found, the physician should be notified. A specific liter flow rate should be ordered when administering oxygen to a resident. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview, on 8/14/25 at 2:29 p.m., LPN 4 indicated a resident on oxygen should have an order with a specific liter flow rate and parameters to titrate. A current facility policy, titled Medication Administration General Guidelines, undated and received from the DON on 8/14/25 at 2:00 p.m., indicated .FIVE RIGHTS .right dose .are applied for each medication being administered. A triple check of these 5 rights is recommended 31-47(a)(6)