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	02/05/2026

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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on observation, interview and record review, the facility failed to ensure a resident who entered the facility without a pressure ulcer did not develop a pressure ulcer and a wound assessment was completed when the wound was discovered for 1 of 3 residents reviewed for pressure ulcers. (Resident C) This deficient practice resulted in Resident C developing a pressure ulcer which was not discovered until it was a stage III (a serious full-thickness skin injury appearing as a deep, crater-like wound which exposes subcutaneous fat) The deficient practice was corrected on 12/2/25, prior to the start of the survey, and was therefore past noncompliance.Findings include:During an observation, on 2/3/26 at 9:52 a.m., Resident C was lying in his bed. His coccyx dressing was dated 2/3/26. He indicated the dressing was changed a few minutes ago.During an interview, on 2/4/26 at 1:25 p.m., Resident C indicated the staff found the sore on his coccyx area when they bathed him. He had complained to staff it was very sore back there prior to them finding the wound.The clinical record for Resident C was reviewed on 2/4/26 at 1:45 p.m. The diagnoses included, but were not limited to, Parkinson's disease, history of falling, incontinence, abnormalities with gait and mobility, muscle weakness, and diarrhea.The Electronic Treatment Administration Record (ETAR), dated November 2025, indicated:a. On 11/1/25 to 11/15/25, hydrocolloid dressing was placed on the resident's coccyx area every other day for a preventative reason.b. On 11/27/25, hydrocolloid dressing was applied to the tailbone after cleansing the wound with soap and water.c. There was no physician order or documentation a preventative dressing was placed on Resident C's coccyx to prevent the stage III pressure ulcer from developing for the dates of 11/15/25 until 11/26/25.A nursing progress note, dated 11/28/25 at 10:25 a.m., indicated Resident C refused to get out of bed. He would not give the facility staff a reason why he refused to get out of bed. The resident was educated on the importance of offloading pressure areas. He voiced understanding, but when the staff attempted to turn and reposition him, he swatted at the staff and stated NO.A facility document, titled Pressure Injury, dated 11/28/25 at 4:00 p.m., indicated the staff reported to LPN 12 (the previous wound nurse) Resident C had a new area on his coccyx. The document indicated Resident C was unaware of the area. The resident was assessed on this date and new treatment orders were obtained. The Nurse Practitioner, DON, and resident's representative were notified of the new area, on 11/27/25.There was no documentation in the clinical record, on 11/27/25, to indicate who found the wound, the time the wound was found, the measurements of the wound, or observations of the wound.The area on his coccyx was not documented as assessed until 11/28/25.A wound summary, dated 11/28/25 at 4:38 p.m., indicated Resident C had a Stage III facility acquired pressure ulcer. The tissue type was 20% non-adherent slough (devitalized, non-viable necrotic tissue, usually yellow or white which sat loosely on the wound bed) and 80% pink or red non-granulating tissue. There was a light amount of serous drainage (clear, thin, watery fluid which leaks from wounds during the initial inflammatory phase of healing) draining from the pressure ulcer. There were no signs or symptoms of infection. The wound measured 6.8 centimeters (cm) in length by 5.6 cm in width by 0.20 cm (continued on next page)

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few	in depth. The resident's wound was found on 11/26/25 at 10:30 p.m.A nursing progress note, dated 11/29/25 at 10:21 a.m., indicated a weekly skin observation was completed. Resident C had a stage III pressure ulcer on his coccyx and to see wound round notes for the wound information.A hospital document, titled Consult Orders, dated 12/3/25 at 1:03 p.m., indicated Resident C was admitted to the hospital from the nursing facility with a pressure injury to his sacrum (coccyx) which was an unstageable pressure ulcer measuring 5.5 cm by 3.8 cm. The wound bed was 30% granulation, 40% slough tissue and 30% eschar tissue (thick, dry, leathery layer of black, brown, or tan dead tissue). The tissue bed description was pink, red, yellow and brown with a scant amount of serosanguinous drainage. The peri wound (skin immediately surrounding the wound) was macerated (softened and whitening skin often caused by prolonged exposure to excessive moisture).A document, titled Initial Wound Evaluation & Management Summary, dated 12/11/25, indicated the wound physician completed an initial wound evaluation on Resident C's coccyx pressure ulcer. Resident C's pressure ulcer was stage III. The wound measured 2.2 cm by 3.0 cm by 0.2 cm. There was no drainage from the wound. The wound bed was 20% slough and 80% granulation tissue. The cause of the wound was pressure.A typed facility statement signed by LPN 12 (the previous wound nurse), undated and provided by the DON on 2/5/26 at 10:10 a.m., indicated on November 26, 2025, he was notified by a night shift nurse Resident C had developed an open area to his coccyx.During an interview, on 2/3/26 at 9:15 a.m., the Director of Nursing (DON) indicated the wound nurse quit approximately two weeks ago, so she and the ADON were sharing responsibility until they could hire another full-time wound nurse.During an interview, on 2/4/26 at 3:25 p.m., the DON indicated the nurse had found the stage III pressure wound on Resident C's coccyx and notified the wound nurse.A current facility policy, titled Skin Condition Assessment & Monitoring-Pressure and Non-Pressure, dated as revised on 6/8/18 and provided by the Executive Director on 2/3/26 at 10:58 a.m., indicated .A wound assessment will be initiated and documented in the resident chart when pressure and/or other non-pressure skin conditions are identified by licensed nurse. Each resident will be observed for skin breakdown daily during care and on the assigned bath day by the CNA. Changes shall be promptly reported to the charge nurse who will perform the detailed assessment.Care givers are responsible for promptly notifying the charge nurse of skin breakdown.The initial observation of the ulcer or skin breakdown will also be described in the nursing progress notes.A disposable measuring device (one time use) will be used to measure dimensions, and if necessary, a clean cotton tipped applicator to measure wound depth/tunneling/undermining.The licensed nurse is responsible for notifying the attending physician, Director of Nursing and legal representative of any suspected wound infection.The deficient practice was corrected by 12/2/25 after the facility implemented a systemic plan that included the following actions: the facility completed resident skin sweeps and assessments, and interventions and care plans were updated accordingly. All nursing staff were educated on the risk for skin breakdown, turning and repositioning, rounding and documentation. Facility rounds were completed to ensure residents were getting up and preventative measures were implemented. The medical director was notified of the incident and reviewed the facility's immediate action plan.This citation relates to Intake 2684665 and 2731672.3.1-40(a)(1)