

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155064	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/10/2026
NAME OF PROVIDER OR SUPPLIER Aperion Care Kokomo		STREET ADDRESS, CITY, STATE, ZIP CODE 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 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 vital signs related to the physician's ordered parameters were obtained, neurological checks were completed after an unwitnessed fall, and a daily weight was obtained as ordered for 3 of 3 residents reviewed for quality of care. (Resident 1, C, and 40) Findings include: 1. The clinical record for Resident 1 was reviewed on 7/8/26 at 10:03 a.m. The diagnoses included, but were not limited to, chronic obstructive pulmonary disease, atrial fibrillation, congestive heart failure, coronary artery disease, and chronic pain. A physician's order, dated 2/13/26, indicated to administer metoprolol succinate (a medication used to treat high blood pressure and manage heart failure) 100 milligrams (mg) once a day and to hold the medication if the systolic blood pressure was less than 110 and/or the heart rate less than 60. A medication administration record (MAR), dated 6/2026, indicated Resident 1's heart rate was not obtained and documented with the administration of the metoprolol succinate. During an interview, on 7/10/26 at 9:31 a.m., LPN 3 indicated if a medication had administration parameters for the blood pressure and heart rate, both should be checked before administration. The vital signs for a medication would be charted on the MAR and/or a note placed to show the medication was held due to being outside of the parameters. During an interview, on 7/10/26 at 9:39 a.m., the Director of Nursing indicated both the blood pressure and pulse should be checked and charted on the MAR or in the vital sign record. When an order was entered into the electronic system, a parameter for the blood pressure or pulse could be checked. It would show up on the MAR and would be documented when the medication was administered. 2. The clinical record for Resident C was reviewed on 7/9/26 at 11:19 a.m. The diagnoses included, but were not limited to, chronic respiratory failure, chronic obstructive pulmonary disease, dementia, congestive heart failure, dependence on supplemental oxygen, anxiety, and depression. A facility fall occurrence note, dated 6/15/26 at 4:00 a.m., indicated Resident C had an unwitnessed fall and was found on the floor. Neurological checks were initiated. The neurological checks for Resident C were documented as completed on 6/15/26 at 4:01 a.m. and 4:31 a.m. There were no other neurological checks documented in the clinical record. During an interview, on 7/10/26 at 12:00 p.m., the Director of Nursing (DON) indicated Resident C was sent to the hospital on 6/15/26 at 11:38 a.m. Neurological checks should have been completed and documented between 4:31 a.m. and the time of transfer. 3. The clinical record for Resident 40 was reviewed on 7/10/26 at 11:41 a.m. The diagnoses included, but were not limited to, congestive heart failure, atrial fibrillation, chronic respiratory failure, anxiety, chronic kidney disease, and high blood pressure. a. A facility fall occurrence note, dated 5/25/26 at 2:00 a.m., indicated Resident 40 had an unwitnessed fall and was observed lying on the floor. Neurological checks were initiated. The neurological checks for Resident 40 were documented as completed on 5/25/26 at 2:00 a.m., 2:15 a.m., 2:30 a.m., 2:47 a.m., and 5:47 p.m., and then on 5/26/26 at 12:50 a.m. and 4:53 a.m. There were no other neurological checks documented in the clinical record. During an interview, on 7/10/26 at 12:21 p.m., LPN 12 indicated (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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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	when a resident fell, a fall report was opened, and neurological checks were automatically triggered for an unwitnessed fall. The neurological checks were to be completed every 15 minutes for 4 times, then every 30 minutes for 4 times, then every hour for 4 hours, and then every shift for 72 hours. b. A care plan, dated 3/18/26, indicated Resident 40 was at risk for decreased cardiac output related to heart failure. Interventions included, but were not limited to, to observe for edema, monitor lab, and report to the physician. A care plan, dated 3/18/26, indicated Resident 40 was on diuretic therapy related to edema. Interventions included, but were not limited to, administer diuretic medication as ordered and monitor for side effects and effectiveness. A physician's order, dated 3/25/26, indicated to obtain a daily weight for Resident 40 related to congestive heart failure and notify the physician if the resident had a weight gain of 3 pounds in a day or 5 pounds in a week. The medication administration record, dated May 2026, indicated there were six (6) days a weight was not obtained and there was no documentation related to a reason for the omission. The medication administration record, dated June 2026, indicated there were six (6) days a weight was not obtained and there was no documentation related to a reason for the omission. During an interview, on 7/10/26 at 9:41 a.m., the Director of Nursing (DON) indicated daily weights were to be obtained before breakfast, when possible. Daily weights were obtained on the day shift unless otherwise ordered. A CNA usually obtained the weight and reported back to the nurse. The nurse would then enter the result on the electronic record. A current facility policy, titled Medication Administration General Guidelines, undated and received from the Administrator in Training on 7/10/26 at 9:18 a.m., indicated .medications are administered in accordance with written orders of the prescriber. A current facility policy, titled Neurological Assessment, dated as revised on 8/1/24 and received from the DON on 7/10/26 at 11:47 a.m., indicated .residents will have a neurological assessment completed.unless otherwise ordered by physician, neuro checks will be completed at the time of.change in condition and every 4 hours for 24 hours. A current facility policy, titled Weights, dated as revised 10/17/19 and received from the DON on 7/10/26 at 11:30 a.m., indicated .each resident shall be weighed.in accordance with physicians orders or plan of care.410 IAC (Indiana Administrative Code) 16.2-3.1-37(a)		