

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 03/04/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  APERION ESTATES PERU, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1200 KITTYHAWK DRIVE PERU, IN 46970
---	---

(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
--------------------	--	---------------	---	----------------------

R 000  Bldg. 00	<p>This visit was for a State Residential Licensure Survey.</p> <p>Survey dates: February 26 &amp; 27, 2015 and March 2 &amp; 4, 2015</p> <p>Facility number: 013327 Provider number: 013327 Aim number: N/A</p> <p>Survey team: Julie Wagoner, RN-TC Debora Kammeyer, RN Lora Swanson, RN</p> <p>Census bed type: Residential: 20 Total: 20</p> <p>Residential sample: 5</p> <p>These state findings are cited in accordance with 410 IAC 16.2-5.</p> <p>Quality Review completed on March 12, 2015, by Brenda Meredith RN.</p>	R 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 A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 03/04/2015	
NAME OF PROVIDER OR SUPPLIER  APERION ESTATES PERU, LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 1200 KITTYHAWK DRIVE PERU, IN 46970			
(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			
R 087  Bldg. 00	<p>410 IAC 16.2-5-1.3(b)(1-3) Administration and Management - Noncompliance (b) The licensee shall provide the number of staff as required to carry out all the functions of the facility, including the following: (1) Initial orientation of all employees. (2) A continuing inservice education and training program for all employees. (3) Provision of supervision for all employees.</p> <p>Based on observation, record review and interviews, the facility failed to ensure there was adequate staff to ensure initial orientation of staff was conducted thoroughly and timely and to ensure there was supervision of staff to ensure abuse investigations were conducted thoroughly and preadmission evaluations and requirements of new residents were obtained timely. (Resident #2, 3, 4, 5, 6)</p> <p>Findings include:</p> <p>Upon entrance to the facility, on 02/26/15 at 11:15 A.M., the Business Office Manager, Employee #13 indicated the Administrator was not in the building. When queried as to the name of the Administrator, she indicated Employee #9 was the Administrator. A few minutes later she indicated Employee #9 was the Administrator in training and the facility currently did not have an Administrator. She indicated the</p>	R 087	<p><b>R087</b> This Plan of Correction isthe center's credible allegation of compliance. Preparation and/or execution of this plan of correctiondoes not constitute admission or agreement by the provider of the truth of thefacts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/orexecuted solely because it is required by the provisions of federal and statelaw. 1) <b>Immediate actionstaken for those residents identified:</b> General orientation documentation has been completed forEmployee #2, 9 and 20. Job specific orientation documentation has been completedfor Employee #5, 9, 15 and 20. Job description has been completed for Employee #9. Criminal history has been completed for Employee #9. TB screen/ mantoux testing has been completed for Employee#5, 9 and 15. Employee #14 was removed from the schedule untilcertification is obtained.</p>	04/03/2015			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 03/04/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  APERION ESTATES PERU, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1200 KITTYHAWK DRIVE PERU, IN 46970
---	---

(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
	<p>Administrator of a sister long term care facility, located in Kokomo, approximately 11 miles south of the facility was going to come fill in during the survey for the Administrator. On 02/26/15 at 12:30 P.M., Employee #13 was queried regarding the status of the Administrator from Kokomo and his expected arrival time. Employee #13 then indicated Employee #20 was the Administrator but would not be available for the next two days as he was out of town at a "training seminar." On 02/26/15 at 1:45 P.M., Employee #9 and an admission staff person from the facility's sister long term care facility, located a block from the facility, had arrived and indicated Employee #9, with a hire date of 10/06/14, was the Administrator in training but had not yet received her preceptor training. She also indicated until 02/25/15, she had been the facility's food service supervisor and had been assisting with admissions and marketing for the facility. The admissions staff person from the facility's sister long term care facility indicated she was going to apply for a provisional Administrator's license and would temporarily be the Administrator for the facility. Finally, on 02/27/15 at 10:00 A.M., Employee #20 was noted in the facility indicated he had a provisional Administrator's license and he had been</p>		<p>Resident #2 and #6- Chest x-ray results were obtained and placed in clinical record. TB/Mantoux testing was completed on Resident #2 and results placed in clinical record. Diet order for Resident #6 was obtained, signed by physician and placed in clinical record. Health statements indicating the residents are free from infectious disease including Tuberculosis were obtained for Residents #3,4,5, 6 and placed in clinical record. Interviews have been completed of other female residents as internal follow up to allegation between Resident #2 and #8. <b>2) How the facility identified other residents:</b> Audit of employee files to ensure appropriate documentation is present, including general orientation, job specific orientation, job description, criminal history, TB screen/ mantoux testing and appropriate certifications. Audit of resident records has been completed to ensure appropriate documentation of pre-admission evaluation and requirements of new residents were obtained timely, including chest x-ray results, TB/Mantoux testing, diet orders and health statements indicating resident is free of infectious disease including tuberculosis. Review of abuse allegations in the last 30 days have been completed to ensure a thorough investigation was completed, including interviews of</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 03/04/2015	
NAME OF PROVIDER OR SUPPLIER  APERION ESTATES PERU, LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 1200 KITTYHAWK DRIVE PERU, IN 46970			
(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			
	<p>the Administrator in the building as well as the corporate manager in charge of the corporations Marketing staff. Review of the provisional Administrator's license indicated it had been granted to Employee #20 on 02/11/15, although the Employee records form indicated his hire/transfer date to the facility, as the Executive Director, was 10/01/15.</p> <p>Review of the Employee records, conducted on 02/27/15 and 03/2/15, indicated when the personnel files were initially reviewed 3 of 6 employees hired in the past year did not have documentation of a general orientation to the facility (Employee #2, 9, and 20), 4 of 6 did not have job specific orientation documentation (Employee #5, 9, 15, and 20), 1 of 6 did not have job descriptions in the file (Employee #9), a criminal history inquiry was not done for 1 of 6 (Employee #9), a health screen and Mantoux testing was not located for 3 of 6 employees (Employee #5, 9, and 15). The facility was able to locate some of the documentation which had been in files, according to Employee #20, at other buildings. However, a criminal history inquiry and specific job orientations could not be located for Employee #9. A general and specific job orientation for Employee #20 could not be located. The job specific orientation located for</p>		<p>other residents and staff as indicated. <b>3) Measures put intoplace/ System changes:</b> New employee files will be audited weekly to ensuredocumentation in files are complete, including general orientation, jobspecific orientation, job description, criminal history, TB screen/ mantouxtesting and appropriate certifications. Director of Nursing or designee will audit all new admissionrecords within 72 hours to ensure clinical record is current and complete. Provisional Administrator and Administrator In Training havebeen re-educated regarding thorough abuse investigation, including interviewsof other residents and staff. Abuse allegation investigations will be reviewed prior tosubmitting 5 day follow up report to ensure the allegation was investigatedthoroughly, including interview of other residents and staff. The Administrator or designee will be responsible foroversight of these audits. <b>4) How the corrective actions will be monitored:</b> The results of theseaudits will be reviewed monthly x3 months, then quarterly x1 for a total of 6months. <b>5) Date of compliance: 4/3/15</b></p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 03/04/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  APERION ESTATES PERU, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1200 KITTYHAWK DRIVE PERU, IN 46970
---	---

(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
	<p>Employee #15 had not been signed by the employee. The general orientation located for Employee #2 had not been signed by the employee. The dementia orientation for the employees had not been dated as to when it had been completed. In addition, on 03/02/15 at 11:30 A.M., Employee #13 indicated Employee #14, who had been working currently as a CNA did not have a current, Indiana CNA certificate and was being removed from the working schedule. Employee #14 had a hire date of 10/27/14.</p> <p>During the survey, conducted on 02/26/15, 02/27/15, 03/02/15 and 03/04/15, five clinical records for residents were reviewed and indicated the following:</p> <ul style="list-style-type: none"> <li>*no chest x-ray completed for 2 of the 5 residents (Resident #2 and 6),</li> <li>*no initial Tuberculin Mantoux testing completed for 1 of the 5 residents (Resident #2 ),</li> <li>*no diet order signed by a physician for 1 of 5 residents (Resident #6),</li> <li>*no health statements indicating the residents were free from infectious diseases, including Tuberculosis for 4 of 5 residents (Residents #3, 4, 5, and 6).</li> </ul> <p>Finally, Employee #9, the AIT indicated on 02/27/15 at 11:00 A.M., there had</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 03/04/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  APERION ESTATES PERU, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1200 KITTYHAWK DRIVE PERU, IN 46970
---	---

(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
	<p>been one allegation of abuse investigated. Employee #20, at the same time, 02/27/15 at 11:00 A.M., seemed unaware of the allegation. Interview with Employee #20, on 03/04/15 at 11:00 A.M. indicated he later recalled being notified of the allegation but was not involved in any way in the investigation of the allegation. Employee #9 indicated she had investigated and reported the allegation and had received direction from the Corporations nursing consultant. Review of the allegation indicated on 12/06/14 sometime after 3:20 P.M., Resident #2 reported to a Certified Nursing Assistant that another male resident had fondled her and "used vulgarities to her stating he wanted to have sex." The investigation indicated both Resident #2 and the other male resident (Resident #8) confirmed the fondling and vulgar statement. Resident #8 indicated he was just teasing Resident #2. The investigation indicated other female residents were not interviewed to ensure Resident #8 had not sexually touched or intimidated any other female resident. Although the allegation was reported, the investigation determined abuse had not occurred because Resident #8 did not intend to "harm" Resident #2.</p> <p>On 2/27/15 at 2:00 P.M., the Administrator in Training provided the</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 03/04/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  APERION ESTATES PERU, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1200 KITTYHAWK DRIVE PERU, IN 46970
---	---

(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
R 088 Bldg. 00	<p>facility's current policy and procedures, dated 01/2012, related to abuse and reporting. The abuse policy included the following: "Sexual Abuse: This includes, but is not limited to, sexual harassment, sexual coercion or sexual assault." The policy and procedure titled "Accidents and Incidents Reporting and Investigation" included the following: "...Sexual Abuse...2. Resident to Resident non-consensual sexual acts...."</p> <p>There were no specific details in the policy regarding how to thoroughly investigate abuse, just a statement that all allegations would be thoroughly investigated.</p> <p>410 IAC 16.2-5-1.3(c)(1-2)(d)(1-2) Administration and Management - Noncompliance c) The licensee shall: (1) appoint an administrator with either a: (A) comprehensive care facility administrator license as required by IC 25-19-1-5(c); or (B) residential care facility administrator</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 03/04/2015	
NAME OF PROVIDER OR SUPPLIER  APERION ESTATES PERU, LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 1200 KITTYHAWK DRIVE PERU, IN 46970			
(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			
	<p>license as required by IC 25-19-1-5(d); and (2) delegate to that administrator the authority to organize and implement the day-to-day operations of the facility. (d) The licensee shall notify the director: (1) within three (3) working days of a vacancy in the administrator's position; and (2) of the name and license number of the replacement administrator</p> <p>Based on record review and interviews, the facility failed to inform the Indiana State Department of Health of a vacancy in the Administrator's position and of the name of the replacement.</p> <p>Finding includes:</p> <p>The presurvey documentation from the Department of Health was reviewed on 02/26/15 at 9:00 A.M. Employee #23 was documented as being the facility's Administrator. Employee #20 was interviewed, on 02/27/15 at 11:00 A.M., and indicated he had been in the "Executive Director " (Administrator's) role since 10/01/14. He indicated it had been a long process but he had received his provisional Administrator's license on 02/11/15. He indicated the former Executive Director, Employee #23, had left her position in September 2014. He was not sure if the Department of Health had been notified of his position change.</p>	R 088	<p><b>R088</b> This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set 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. <b>1) Immediate action taken for those residents identified:</b> Indiana State Department of Health was notified on 3-19-15 of change in Provisional Administrator effective date 2-1-15. <b>2) How the facility identified other residents:</b> No further changes have been made at this time requiring notification. <b>3) Measures put into place/ System changes:</b> An audit will be completed within 3 working days of a vacancy in the Administrator position to ensure that the Indiana State Department of Health was notified of vacancy and provided the name and license number of the</p>	04/03/2015			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 03/04/2015	
NAME OF PROVIDER OR SUPPLIER  APERION ESTATES PERU, LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 1200 KITTYHAWK DRIVE PERU, IN 46970			
(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
R 116 Bldg. 00	<p>410 IAC 16.2-5-1.4(a) Personnel - Noncompliance (a) Each facility shall have specific procedures written and implemented for the screening of prospective employees. Appropriate inquiries shall be made for prospective employees. The facility shall have a personnel policy that considers references and any convictions in accordance with IC 16-28-13-3. Based on record review and interviews, the facility failed to ensure a criminal history inquiry was obtained for 1 of 6 employees reviewed. (Employee #9)</p> <p>Finding includes:</p> <p>The personnel file for Employee #9 was reviewed on 02/27/15 and 03/02/15. The file did not contain documentation of a criminal history inquiry obtained upon her hire date of 10/06/14.</p> <p>During an interview, on 03/04/15 at 1:30 P.M., the Executive Director, Employee #20, indicated he could not locate a</p>			R 116	<p>replacement administrator or provisional administrator. The Human Resources Director or designee will be responsible for oversight of this audit. <b>4) How the corrective actions will be monitored:</b> The results of these audits will be reviewed monthly x3 months, then quarterly x1 for a total of 6 months. <b>5) Date of compliance: 4/3/15</b></p> <p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set 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.</i></p>		04/03/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 03/04/2015	
NAME OF PROVIDER OR SUPPLIER  APERION ESTATES PERU, LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 1200 KITTYHAWK DRIVE PERU, IN 46970			
(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			
R 117	<p>criminal history for Employee #9 but he thought he remember reading the inquiry results in the past.</p> <p>The facility's current policy and procedure, titled "Abuse," dated 01/2012, provided by the Administrator in Training, on 02/27/15 at 2:00 P.M., included the following: "...3. The facility will do a "criminal record check" on all unlicensed staff according to Indiana law...."</p>		<p><b>1) Immediate actionstaken for those residents identified:</b></p> <p>Criminal history inquiry was completed for Employee #9.</p> <p><b>2) How the facilityidentified other residents:</b></p> <p>An audit was completed of all employee files to ensurecriminal history inquiry had been completed. No other employees were identified.</p> <p><b>3) Measures put intoplace/ System changes:</b></p> <p>New employee files will be reviewed weekly to ensurecriminal history inquiry has been submitted upon hire.</p> <p>The Administrator or designee will be responsible foroversight of these audits.</p> <p><b>4) How the corrective actions will be monitored:</b></p> <p>The results of theseaudits will be reviewed monthly x3 months, then quarterly x1 for a total of 6months.</p> <p><b>5) Date ofcompliance: 4/3/15</b></p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 03/04/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  APERION ESTATES PERU, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1200 KITTYHAWK DRIVE PERU, IN 46970
---	---

(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
--------------------	--	---------------	---	----------------------

Bldg. 00	<p><b>Personnel - Deficiency</b></p> <p>(b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions. Based on record review and interviews, the facility failed to ensure there was sufficient staff, including at least one awake, CPR certified staff working at all times.</p> <p>Finding includes:</p> <p>Review of the February 2014 working schedule for the facility regarding staffing indicated on the second and third shift there was only one nursing staff</p>	R 117	<p><b>R 117</b></p> <p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The</i></p>	04/03/2015
----------	--	-------	--	------------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 03/04/2015	
NAME OF PROVIDER OR SUPPLIER  APERION ESTATES PERU, LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 1200 KITTYHAWK DRIVE PERU, IN 46970			
(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			
	<p>member working in the facility. The staff member was the only staff member for the last half of the second shift and the entire third shift. CNA #14 worked 15 night shifts alone in the building in February 2015. CNA #8 worked 3 night shifts alone in the building in February 2015. CNA #15 worked 8 night shifts alone in the building and 5 evening shifts alone in the building for all or part of her shifts in February 2015.</p> <p>Review of the Personnel files, on 02/27/15 and 03/02/15 indicated Employee #14, had no CNA certification and did not have a first aide certification. Employees #8 and #15 had online CPR certifications (without any hands on training).</p> <p>During an interview, on 03/02/15 at 11:00 A.M., the Administrator in training (AIT) indicated she was not aware the online CPR certifications were not acceptable to meet the requirement.</p>		<p><i>plan of correction is prepared and/or executed solely because it is required by the provisions of federal and statelaw.</i></p> <p><b>1) Immediate action taken for those residents identified:</b></p> <p>Employee #8 and #15 will be scheduled to have hands on CPR training and skills checkoff completed. Employee #14 has been removed from facility schedule until CNA certification is completed.</p> <p><b>2) How the facility identified other residents:</b></p> <p>All employee files have been reviewed. Employees identified without hands on CPR training will complete training by 4/4/15. No other CNA's were identified without current CNA certification.</p> <p><b>3) Measures put into place/ System changes:</b></p> <p>New CNA employee files will be reviewed prior to staff providing direct care to ensure current hands on CPR and CNA certifications are present.</p> <p>The Administrator or designee will</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 03/04/2015	
NAME OF PROVIDER OR SUPPLIER  APERION ESTATES PERU, LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 1200 KITTYHAWK DRIVE PERU, IN 46970			
(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
R 118 Bldg. 00	<p>410 IAC 16.2-5-1.4(c) Personnel - Deficiency (c) Any unlicensed employee providing more than limited assistance with the activities of daily living must be either a certified nurse aide or a home health aide. Existing facilities that are not licensed on the date of adoption of this rule and that seek licensure within one (1) year of adoption of this rule have two (2) months in which to ensure that all employees in this category are either a certified nurse aide or a home health aide. Based on record review and interviews, the facility failed to ensure 1 of 9 employees working as a nursing assistant was certified. (Employee #14)</p> <p>Finding includes:</p> <p>On 03/02/14 at 10:30 A.M., the certifications and licenses of nursing staff were reviewed. There was no current certification for Employee #14, listed as a CNA (certified nursing assistant), hired on 10/27/14. During an interview, on</p>			R 118	<p>beresponsible for oversight of these audits.</p> <p><b>4) How the corrective actions will be monitored:</b></p> <p>The results of these audits will be reviewed monthly x3 months, then quarterly x1 for a total of 6months.</p> <p><b>5) Date of compliance: 4/3/15</b></p> <p><b>R118</b></p> <p><b>The facility request paper compliance for this citation.</b></p> <p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The</i></p>		04/03/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 03/04/2015	
NAME OF PROVIDER OR SUPPLIER  APERION ESTATES PERU, LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 1200 KITTYHAWK DRIVE PERU, IN 46970			
(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
	<p>03/02/15 at 11:45 A.M., the Business Office Manager indicated Employee #14 did not have a current Indiana certification as a nursing assistant and had been removed from the working schedule. Review of the working schedule for nursing staff for February 2014 indicated his last day to work had been 02/25/15 when he worked the night shift as the only nursing staff member.</p> <p>The facility had a census of 20 residents. The staff duties included, but were not limited to: toileting and transferring.</p>				<p><i>plan of correction is prepared and/or executed solely because it is required by the provisions of federal and statelaw.</i></p> <p><b>1) Immediate action taken for those residents identified:</b></p> <p>Employee #14 has been removed from facility schedule until CNA certification is completed.</p> <p><b>2) How the facility identified other residents:</b></p> <p>All employee files have been reviewed. No other CNA's were identified without current CNA certification.</p> <p><b>3) Measures put into place/ System changes:</b></p> <p>New CNA employee files will be reviewed prior to staff providing direct care to ensure current CNA certifications are present.</p> <p>An audit will be completed of employee files monthly to ensure appropriate staff have current CNA certifications as required.</p> <p>The Administrator or designee will be responsible for oversight of this audit.</p> <p><b>4) How the corrective actions will be monitored:</b></p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 03/04/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  APERION ESTATES PERU, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1200 KITTYHAWK DRIVE PERU, IN 46970
---	---

(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
R 119 Bldg. 00	<p>410 IAC 16.2-5-1.4(d)(1)(A-E)(2)(A-D)(3- Personnel - Noncompliance</p> <p>(d) Prior to working independently, each employee shall be given an orientation to the facility by the supervisor (or his or her designee) of the department in which the employee will work. Orientation of all employees shall include the following:</p> <p>(1) Instructions on the needs of the specialized populations:</p> <p>(A) aged;</p> <p>(B) developmentally disabled;</p> <p>(C) mentally ill;</p> <p>(D) dementia; or</p> <p>(E) children;</p> <p>served in the facility.</p> <p>(2) A review of the facility's policy manual and applicable procedures, including:</p> <p>(A) organization chart;</p> <p>(B) personnel policies;</p> <p>(C) appearance and grooming policies for employees; and</p> <p>(D) residents' rights.</p> <p>(3) Instruction in first aid, emergency procedures, and fire and disaster preparedness, including evacuation procedures.</p> <p>(4) Review of ethical considerations and confidentiality in resident care and records.</p> <p>(5) For direct care staff, personal introduction to, and instruction in, the particular needs of each resident to whom the employee will be providing care.</p>		<p>The results of these audits will be reviewed monthly x3 months, then quarterly x1 for a total of 6months.</p> <p><b>5) Date of compliance: 4/3/15</b></p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 03/04/2015	
NAME OF PROVIDER OR SUPPLIER  APERION ESTATES PERU, LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 1200 KITTYHAWK DRIVE PERU, IN 46970			
(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			
	<p>(6) Documentation of the orientation in the employee's personnel record by the person supervising the orientation.</p> <p>Based on record review and interviews, the facility failed to ensure there was documentation of job specific orientations for 2 of 6 personnel files reviewed. (Employee #9 and 20)</p> <p>Finding includes:</p> <p>1. Personnel files for 6 employees hired in the past 6 months were reviewed on 02/27/15 at 1:30 P.M. and indicated the following:</p> <p>A. There was no job specific orientation for Employee #9, who was hired on 10/06/14 as the Administrator in Training. During an interview, on 02/26/15 at 1:20 P.M., Employee #9 indicated she was the Food Service Supervisor and helped with Admissions until 02/25/15 when she became the Administrator in Training. She indicated she had not started or received any of her Administrator training.</p> <p>During an interview, conducted on 02/28/15 at 1:45 P.M., the Administrator, Employee #20, indicated the documentation for Employee #9 was probably in a file in a sister facility's office in a nearby town.</p>	R 119	<p><b>R119</b></p> <p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set 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 statelaw.</i></p> <p><b>1) Immediate action taken for those residents identified:</b></p> <p>Employee #9 and #20 have completed documentation of job specific orientation and placed in employee file.</p> <p><b>2) How the facility identified other residents:</b></p> <p>All employee files have been reviewed to ensure documentation of job specific orientation is present.</p> <p><b>3) Measures put into place/ System changes:</b></p>	04/03/2015			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 03/04/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  APERION ESTATES PERU, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1200 KITTYHAWK DRIVE PERU, IN 46970
---	---

(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
	<p>On 03/02/15 at 9:30 A.M., Employee #9 provided her personnel file documentation with job descriptions, signed on 10/06/14 for herself, for the Food Service Supervisor, the Director of Admission, and the Director of Marketing but there was no job specific orientations presented for those positions.</p> <p>B. There was no job specific orientation for Employee #20, who was hired on 10/01/15 as the Administrator.</p> <p>During an interview, conducted on 02/27/15 at 10:40 A.M., the Administrator, Employee #20 indicated he had received his provisional Administrator's license on 02/11/15. In addition, he indicated the facility's previous administrator had left in September 2014, and the facility had been acquired by an out of state corporation, and the administration of the facility had been "a challenge." He indicated he was also responsible for regional Marketing employees in several long term care facilities.</p>		<p>An audit will be completed of newemployee files and any employees with internal position changes weekly toensure documentation of job specific orientation is present.</p> <p>The Administrator or designee will be responsible for oversight of these audits.</p> <p><b>4) How the corrective actions will be monitored:</b></p> <p>The results of these audits will be reviewed monthly x3 months, then quarterly x1 for a total of 6months.</p> <p><b>5) Date of compliance: 4/3/15</b></p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 03/04/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  APERION ESTATES PERU, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1200 KITTYHAWK DRIVE PERU, IN 46970
---	---

(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
R 157  Bldg. 00	<p>410 IAC 16.2-5-1.5(n) Sanitation and Safety Standards - Deficiency n) The facility shall develop, adopt, and implement written policies and procedures on cleaning, disinfecting, and sterilizing equipment used by more than one (1) person in a common area.</p> <p>Based on observations, interview and record reviews, the facility failed to sanitize 2 of 2 washing machines used in a common area.</p> <p>Finding includes:</p> <p>During the initial tour conducted on 2/26/15 from 11:25 A.M. thru 11:45 A.M., two washing machines were observed in a common area. After opening both washers, the surface around the tub was observed to have hair, dust, and a light brown substance on its surface. Both softener dispensers had a blue sticky film covering it. Both bleach dispensers had dust and a light brown substance in its base.</p> <p>During the general observation tour on 3/2/15 at 1:40 P.M., the Maintenance Director was observed opening two washing machines. The Maintenance Director indicated the surface around the tubs were "dirty" and a staff person was to cleanse out the machines every night. The tubs were observed to have a blue film along the stainless steel wash tub.</p>	R 157	<p><b>R157</b></p> <p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set 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.</i></p> <p><b>1) Immediate action taken for those residents identified:</b></p> <p>Washing machines identified were sanitized.</p> <p><b>2) How the facility identified other residents:</b></p> <p>Facility has 2 washing machines and 2 dryers. All washing machines and dryers were checked and cleaned.</p> <p><b>3) Measures put into place/ System changes:</b></p>	04/03/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 03/04/2015	
NAME OF PROVIDER OR SUPPLIER  APERION ESTATES PERU, LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 1200 KITTYHAWK DRIVE PERU, IN 46970			
(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			
	<p>He was then observed pulling out each of the washer's softener dispensers. The softener dispensers were covered with a blue thick substance. The area underneath the dispensers, which remained in the washer, had a thick blue film lining the surface and approximately 1/4 inch of thick blue substance lying on the bottom. The Maintenance Director indicated the area should be filled with warm water and removed with a shop vacuum during the night shift. He further indicated the cleansing process for the 2 softener dispensers had not been completed as directed due to the appearance of each of them. One of the washers had the cloth napkins the resident's had used during a previous meal.</p> <p>On 3/2/15 at 2:00 P.M., a form titled, "Night Shift 3 PM-7 AM CNA (Certified Nursing Assistant) Duties," dated 3/1/15, indicated the CNA was to clean off the tops of the washer and dryer.</p> <p>On 3/2/15 at 2:15 P.M., a current policy titled, "Washer and Dryer Cleaning," undated, was received from the Maintenance Director. The policy indicated the following: "...Open the top of the washer clean the inside...Remove softener dispenser and clean the inside...Clean the dryer vents...."</p>		<p>Nursing staff were re-educated regarding cleaning and sanitizing procedure for washing machines and dryers.</p> <p>Random audits will be completed at least 3 times per week to ensure washing machines and dryers are sanitized and cleaned as required.</p> <p>The Maintenance Director or Administrator/designee will be responsible for oversight of these audits.</p> <p><b>4) How the corrective actions will be monitored:</b></p> <p>The results of these audits will be reviewed monthly x3 months, then quarterly x1 for a total of 6 months.</p> <p><b>5) Date of compliance: 4/3/15</b></p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 03/04/2015	
NAME OF PROVIDER OR SUPPLIER  APERION ESTATES PERU, LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 1200 KITTYHAWK DRIVE PERU, IN 46970			
(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			
R 241 Bldg. 00	<p>410 IAC 16.2-5-4(e)(1) Health Services - Offense (e) The administration of medications and the provision of residential nursing care shall be as ordered by the resident ' s physician and shall be supervised by a licensed nurse on the premises or on call as follows: (1) Medication shall be administered by licensed nursing personnel or qualified medication aides.</p> <p>Based on record review, observation, and interview, the facility failed to ensure that residents medications were administered by licensed nursing personnel or a qualified medication aide. This had the potential to affect 2 of 5 resident's reviewed for medication administration. (Resident #6 and Resident #5)</p> <p>Findings include:</p> <p>1. Resident #6 was observed, on 02/26/15 during the noon meal, sitting in a wheelchair in the dining room. The resident was noted to be leaning forward in his wheelchair and actively drooling. The resident did not speak when greeted but was noted to feed himself his lunch.</p> <p>The clinical record for Resident #6 was reviewed on 02/27/15 at 2:00 P.M. Resident #6 was admitted to the facility on 11/10/14 with diagnosis, including but</p>	R 241	<p><b>R241</b></p> <p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set 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 statelaw.</i></p> <p><b>1) Immediate action taken for those residents identified:</b></p> <p>Residents #5 and #6 have been re-evaluated to determine if assistance is required for medication self-administration.</p>	04/03/2015			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 03/04/2015	
NAME OF PROVIDER OR SUPPLIER  APERION ESTATES PERU, LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 1200 KITTYHAWK DRIVE PERU, IN 46970			
(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			
	<p>not limited to, hypertension and major depression.</p> <p>An assessment for Self Administration of Medications was completed on admission for Resident #6. The assessment indicated Resident #6 could correctly read a pharmacy label, state the name and reason for each medication, state the medication side effects, state the time the medication was to be taken, remove the medication from the packaging, correctly measure the appropriate amounts of medication from a container, demonstrate secure storage for medication, correctly use any devices need to administer medications. The decision to mark if the resident was able to safely self administer medications was left blank. Under the comments section was written, "Family to set meds up. Staff will do med [medication] reminders."</p> <p>During an interview and observation, on 03/04/15 at 1:12 P.M. and 1:50 P.M., CNA #7 indicated and later demonstrated how she entered Resident #6's apartment, retrieved a key hidden in an upper kitchenette cabinet, unlocked a drawer in his kitchenette, retrieved a paper pharmacy prepared daily medication holder, tore the paper top off of the appropriate date and time and then would dump the medications into the hand of</p>		<p><b>2) How the facility identified other residents:</b></p> <p>All residents will bere-evaluated to identify those that require assistance with medicationadministration.</p> <p><b>3) Measures put intoplace/ System changes:</b></p> <p>Medication Self-Administration tool will be revised toaccurately reflect the resident needs for medication administration.</p> <p>Medication Self-Administration Assessment will be completedupon admission and reviewed with significant change in condition and/or every 90days for residents on Medicaid Waiver, and every 6 months for Non-Medicaidwaiver.</p> <p>CNA's will be re-educated regarding scope of practice formedication reminders and verbal cues.</p> <p>Licensed nurse or QMA will administer medication to thoseresidents who do not meet criteria for self-administration of medications withverbal cueing/reminders.</p> <p>The Director of Nursing or designee will be responsible foroversight of these audits.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 03/04/2015	
NAME OF PROVIDER OR SUPPLIER  APERION ESTATES PERU, LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 1200 KITTYHAWK DRIVE PERU, IN 46970			
(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			
	<p>Resident #6. She indicated although she did not think Resident #6 would initiate the process she thought he would gesture to her if she tried to administer medications at a wrong time. She indicated she had no idea what medications Resident #6 took she just gave them to him.</p> <p>2. On 2/27/15 at 10:00 A.M., the clinical record for Resident #5 was reviewed. Resident #5 was admitted on 11/5/14 with diagnoses included, but not limited to: "...atrial fib, hyperlipidemia, hypertension, pericardial effusion, pneumonia and frequent falls...."</p> <p>A form titled, "Assessment for Self Administering Medications," dated 11/3/14, indicated, "...1. Can the resident correctly read print on pharmacy label? Answer marked No. 2. Can resident correctly state name and reason for each med? Answer marked No. 3. Can resident correctly state common side effects of each med? Answer marked No...5. Can resident correctly state what time meds are to be taken? Answer marked No...8. Can resident correctly document self administration of med? Answer marked No. 9. Can resident demonstrate secure storage for med? Answer marked No...Interdisciplinary Team Evaluation: 1. The interdisciplinary</p>		<p><b>4) How the corrective actions will be monitored:</b></p> <p>The results of these audits will be reviewed monthly x3 months, then quarterly x1 for a total of 6months.</p> <p><b>5) Date of compliance: 4/3/15</b></p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 03/04/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  APERION ESTATES PERU, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1200 KITTYHAWK DRIVE PERU, IN 46970
---	---

(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
	<p>team has determined that the resident is able to safely self administer medications? Answer marked No...At the bottom of the form a hand written notation indicated, needs med set up and reminders...."</p> <p>A form titled, "Service Plan of Care," dated 11/6/14, indicated, "...Medication Administration: Interventions: Staff to provide medication reminders for resident. Family to set up medications...."</p> <p>On 3/4/15 at 1:30 P.M., Certified Nursing Assistant, CNA #7, was observed entering Resident #5's room and demonstrated how she reminds the resident that it is time to take his medication. CNA #7 proceeded to remove a key from a cabinet above the resident's sink, she then unlocked a drawer located beside the sink and removed a plastic container that was color coded, she flipped up a blue plastic tab and handed the resident the plastic container. Resident #5 at that time indicated "Is it time to take my medicine again?" CNA #7 informed the resident that she was just demonstrating how she reminds him of his medication and that it was not time to take his pills.</p> <p>During an interview, on 3/4/15 at 1:40 P.M., CNA #7 indicated she opens the</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 03/04/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  APERION ESTATES PERU, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1200 KITTYHAWK DRIVE PERU, IN 46970
---	---

(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
R 273 Bldg. 00	<p>color coded plastic lids for the resident as a "time saving" step. She further indicated she assumed the resident could do it himself if he needed to.</p> <p>The current facility policy entitled, "Pharmaceutical Services," dated May 9, 2014, received from the Director of Nursing on 3/2/15 at 9:05 A.M., indicated, "...It is the policy of this facility to provide assistance with medication administration as needed or requested within staff limitations. The facility DOES NOT have licensed nursing staff available to administer medications. Staff may provide cueing and/or prompting of the resident to take their medication...3. Residents will be assessed by administering the "Self Administration" assessment tool every six (6) months to assure competency in self-medication administration...."</p> <p>410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation, record review and</p>	R 273	R273	04/03/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 03/04/2015	
NAME OF PROVIDER OR SUPPLIER  APERION ESTATES PERU, LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 1200 KITTYHAWK DRIVE PERU, IN 46970			
(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			
	<p>interview, the facility failed to ensure the refuse container in the kitchen was equipped to ensure hands free lifting of the lid. The facility also failed to serve food under sanitary conditions related to the use of gloves. This deficiency had the potential to affect 17 of 17 resident's receiving meals from 1 of 1 kitchen.</p> <p>Findings include:</p> <p>1. During the initial kitchen tour, conducted on 2/26/15 between 2:15 P.M. to 2:45 P.M., the following was observed:</p> <p>A large rubber garbage canister with no lid on it was located at the end of the food prep table. The canister had a plastic bag lining it and had refuse inside of the bag.</p> <p>On 2/27/15 at 11:15 A.M., during a revisit of the kitchen the following was observed:</p> <p>A large rubber garbage canister with a lid on it was located at the end of the food prep table. No foot pedal was observed at the base of the garbage canister to assist in hands free opening of the lid.</p> <p>During an interview on 3/2/15 at 2:15 P.M., the Food Service Supervisor (FSS)</p>		<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set 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.</i></p> <p><b>1) Immediate action taken for those residents identified:</b></p> <p>Hands free refuse container has been obtained. Employee #1 and #2 were re-educated regarding proper food handling and sanitation.</p> <p><b>2) How the facility identified other residents:</b></p> <p>All residents have the potential to be affected.</p> <p><b>3) Measures put into place/ System changes:</b></p> <p>Dietary, nursing and activity staff will be re-educated regarding proper food handling and sanitation.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 03/04/2015	
NAME OF PROVIDER OR SUPPLIER  APERION ESTATES PERU, LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 1200 KITTYHAWK DRIVE PERU, IN 46970			
(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
	<p>indicated the garbage canister in the kitchen does not have a foot pedal and that she would contact the Administrator and have one ordered.</p> <p>2. During the observation of the noon meal service, conducted on 2/26/15 between 11:30 A.M. to 12:05 P.M., the FSS, Employee #1, was noted to use her gloved hands to remove the foil from the top of the steam pans, rearrange resident menus, open the refrigerator door and remove a cup of cottage cheese and then deliver it to a resident seated at a dining room table, wrapped two plates of food with plastic, picked up ladles on the steam table and reached into a plastic bag and removed slices of bread with her contaminated gloved hands. The FSS was not observed to change her gloves during the entire meal service.</p> <p>During the observation of the noon meal service, conducted on 2/27/15 between 11:35 A.M. to 11:55 A.M., Dietary Aide, Employee #2, was noted to use her gloved hands to open a refrigerator door and remove butter, she then opened the lid of a portable griddle that was on the counter. Employee #2 then reached in with her gloved hands and removed 6 slices of bread from a plastic bag and assembled 3 cheese sandwiches and placed each of them on the griddle.</p>				<p>Random observation audits will be completed at least 3 times per week at varied meals to ensure that food handling procedure is being followed and hands free refuse container is properly used.</p> <p>The Administrator or designee will be responsible for oversight of these audits.</p> <p><b>4) How the corrective actions will be monitored:</b></p> <p>The results of these audits will be reviewed monthly x3 months, then quarterly x1 for a total of 6 months.</p> <p><b>5) Date of compliance: 4/3/15</b></p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 03/04/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  APERION ESTATES PERU, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1200 KITTYHAWK DRIVE PERU, IN 46970
---	---

(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
R 349 Bldg. 00	<p>Employee #2 was then observed flipping the cheese sandwiches with her contaminated gloved hands. Employee #2 was not observed to change her gloves during the entire meal service.</p> <p>On 3/2/15 at 9:15 A.M., record review of the current policy titled "Dietary Department Guidelines" received from the Director of Nursing indicated "...GLOVE USE...(a) If used, single-use gloves shall be: (1) used for only one (1) task, such as working with ready-to-eat food...(3) discarded when: (B) interruptions occur in the operation...."</p> <p>410 IAC 16.2-5-8.1(a)(1-4) Clinical Records - Noncompliance (a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized.</p> <p>Based on interview and record review, the facility failed to have complete and current clinical records containing a list of current medications, a mental health screen and an order for self</p>	R 349	<p><b>R349</b></p> <p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p>	04/03/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 03/04/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  APERION ESTATES PERU, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1200 KITTYHAWK DRIVE PERU, IN 46970
---	---

(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
	<p>administration of medications for 1 of 5 resident's reviewed. (Resident#2)</p> <p>Finding includes:</p> <p>On 2/26/15 at 2:00 P.M. the Administrator in Training presented a list of resident names who currently received a medicaid wavier.</p> <p>On 2/27/15 at 9:20 A.M., a review of the clinical record for Resident #2 was conducted. The record indicated the resident was admitted on 11/1/14. The resident's diagnoses included, but were not limited to: chronic back pain, mild mental retardation, diabetes and chronic obstructive pulmonary disease.</p> <p>An assessment for self-administration of medications, dated 10/31/14, indicated the resident was able to safely self administer medications. The assessment instructions indicated "...Before performing this assessment verify that there is a physician order for self administration of the specific medication under consideration...."</p> <p>The physician orders section of the medical record did not contain a list of the resident's medications or an order for the resident to self administer her medications.</p>		<p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set 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.</i></p> <p><b>1) Immediate action taken for those residents identified:</b></p> <p>Resident #2- Current medication list, mental health screen and order to self-administer medications were obtained and placed in file.</p> <p><b>2) How the facility identified other residents:</b></p> <p>An audit of resident records will be completed to ensure that a current medication list, mental health screen and order to self-administer medication is present as indicated. Corrections will be made as identified.</p> <p><b>3) Measures put into place/ System changes:</b></p> <p>An audit will be completed on all new admission records within 72 hours to ensure clinical record is current and complete.</p> <p>The Director of Nursing or designee will be responsible for oversight of</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 03/04/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  APERION ESTATES PERU, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1200 KITTYHAWK DRIVE PERU, IN 46970
---	---

(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
	<p>A prescription history, dated 11/21/14, was located under the admission record tab of the chart and listed the following medications used by the resident: clotrimazole, potassium, glipizide, metformin, lidoderm patch, norco, zanaflex, lasix, zaroxclyn, lyrica and flagyl.</p> <p>A Service Plan-Plan of Care, dated 11-1-14, indicated the goal of medication administration for Resident #2 was to administer medications per MD (Medical Doctor) recommendation.</p> <p>The clinical record did not contain a mental health screen.</p> <p>On 2/27/15 at 9:35 A.M., the resident's room was observed to have Lantus (insulin) injectable pen at her bedside.</p> <p>During an interview, on 2/27/15 at 9:40 A.M., the Administrator in training indicated a mental health screen wasn't needed for the resident as the wavier was originally for HUD (Department of Housing and Urban Development) and the resident might be taken off the wavier. The Administrator in Training determined there was no documentation indicating Resident #2 received a mental health screen prior to her admission.</p>		<p>these audits.</p> <p><b>4) How the corrective actions will be monitored:</b></p> <p>The results of these audits will be reviewed monthly x3 months, then quarterly x1 for a total of 6 months.</p> <p><b>5) Date of compliance: 4/3/15</b></p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 03/04/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  APERION ESTATES PERU, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1200 KITTYHAWK DRIVE PERU, IN 46970
---	---

(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
	<p>During an interview, on 2/27/15 at 10:00 A.M., the Director of Nursing (DON) indicated the resident was a diabetic and was taking insulin as she had observed insulin in the resident's room. The DON indicated she had no physician order reflecting the resident's use of insulin, dosage, type of insulin, nor administration times. The DON further indicated the resident's medication list was faxed to the facility on 11-21-14, days after the resident was admitted.</p> <p>On 2/27/15 at 1:45 P.M., a current policy, dated 4/4/14, titled "Medical Record Policy" was received from the Administrator in Training. The policy indicated "...It is the policy of the facility that an information system including a resident's record will be maintained for each resident, diagnosis, and promote continuity of care among health providers...7. The resident clinical record shall contain at least the following:...e. Service notes relating to the resident...3) Medication...."</p> <p>On 3/4/15 at 10:10 A.M., the resident handbook was reviewed and on page 19, indicated "...Staff Members...Director of Nursing: As appropriate, the DON, a licensed nurse, is responsible for overseeing medication management,</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 03/04/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  APERION ESTATES PERU, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1200 KITTYHAWK DRIVE PERU, IN 46970
---	---

(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
R 408 Bldg. 00	<p>treatments, and coordination of the residents' overall health and services, including doctors' appointments, personal care and other health services provided by the Residence and other health care providers...."</p> <p>During an interview, on 3/4/15 at 1:34 P.M., the Administrator in Training indicated the resident received the "Resident Handbook" from her but she had no signature from the resident signifying the transaction.</p> <p>410 IAC 16.2-5-12(c) Infection Control - Noncompliance (c) Each resident shall have a diagnostic chest x-ray completed no more than six (6) months prior to admission. Based on record reviews and interviews the facility failed to ensure 2 of 5 residents reviewed had obtained a diagnostic chest x-ray prior to admission. (Resident #2 and Resident #6)</p> <p>Findings include:</p> <p>1. On 2/27/15 at 9:20 A.M., a review of the clinical record for Resident #2 was conducted. The record indicated the</p>	R 408	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The</i></p>	04/03/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 03/04/2015	
NAME OF PROVIDER OR SUPPLIER  APERION ESTATES PERU, LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 1200 KITTYHAWK DRIVE PERU, IN 46970			
(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			
	<p>resident was admitted on 11/1/14. The resident's diagnoses included, but were not limited to: chronic back pain, mild mental retardation, diabetes, and chronic obstructive pulmonary disease.</p> <p>A chest x-ray, dated 1-27-15, indicated the resident had no evidence of active tuberculosis. This chest x-ray was not completed prior to the resident's admission date of 11/1/14.</p> <p>On 3/2/15 at 11:30 A.M., the Director of Nursing provided a policy titled "Policy for Tuberculosis Testing of Resident" and indicated the policy was the one currently used by the facility in regards to a chest x-ray. The policy indicated a resident who has a new positive Mantoux (TB Test) " will be evaluated by their own physician or the Medical Director to determine if they are infected with TB or have active TB disease. This will routinely include a chest x-ray and evaluation as deemed necessary by their own physician or the Medical Director to determine their risk of developing active tuberculosis..." There was no policy to have a chest xray completed no more than six months prior to admission.</p> <p>2. The clinical record for Resident #6 was reviewed on 02/27/15 at 2:00 P.M. Resident #6 was admitted to the facility</p>		<p><i>plan of correction is prepared and/or executed solely because it is required by the provisions of federal and statelaw.</i></p> <p><b>1) Immediate action taken for those residents identified:</b></p> <p>Resident #6- Chest x-ray results were obtained and placed in clinical record.</p> <p><b>2) How the facility identified other residents:</b></p> <p>An audit will be completed of all current resident clinical records to identify any other residents affected.</p> <p><b>3) Measures put into place/ System changes:</b></p> <p>All potential admissions will be screened prior to admission to ensure chest x-ray has been completed no more than 6 months prior to admission.</p> <p>An audit will be completed on all new admission records within 72 hours to ensure chest x-ray results are present and completed in the appropriate time frame.</p> <p>The Director of Nursing or designee will be responsible for oversight of these audits.</p> <p><b>4) How the corrective actions will be monitored:</b></p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 03/04/2015	
NAME OF PROVIDER OR SUPPLIER  APERION ESTATES PERU, LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 1200 KITTYHAWK DRIVE PERU, IN 46970			
(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			
R 409 Bldg. 00	<p>on 11/10/14. There was no chest xray located in the clinical record for Resident #6.</p> <p>During an interview on 2/27/15 at 2:45 P.M., the director of Nursing indicated she would look for a chest X-ray. A faxed copy of a chest X-ray for Resident #6 was presented on 03/02/15 at 9:30 A.M. The chest X-ray had been completed on 01/27/15, over two months after Resident #6 was admitted to the facility.</p> <p>410 IAC 16.2-5-12(d) Infection Control - Noncompliance (d) Prior to admission, each resident shall be required to have a health assessment, including history of significant past or present infectious diseases and a statement that the resident shows no evidence of tuberculosis in an infectious stage as verified upon admission and yearly thereafter.</p> <p>Based on record review and interview the facility failed to ensure prior to admission and/or annually a health statement that indicated the residents were free of tuberculosis or any other communicable diseases was completed for 4 of 5</p>	R 409	<p>The results of these audits will be reviewed monthly x3 months, then quarterly x1 for a total of 6 months.</p> <p><b>5) Date of compliance: 4/3/15</b></p> <p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p>	04/03/2015			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 03/04/2015	
NAME OF PROVIDER OR SUPPLIER  APERION ESTATES PERU, LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 1200 KITTYHAWK DRIVE PERU, IN 46970			
(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			
	<p>resident's reviewed. (Resident #3, Resident #4, Resident #5 and Resident #6)</p> <p>Findings include:</p> <p>1. On 2/27/15 at 10:00 A.M., record review indicated Resident #5's admission date to the facility was 11/5/14 and his diagnosis included but were not limited to: "...atrial fibrillation, hyperlipidemia, hypertension, pericardial effusion, frequent falls and right knee replacement..." Further review of the medical record indicated a physician progress note was completed on 9/25/14 and did not include a statement that the resident was free of tuberculosis or other communicable diseases.</p> <p>During an interview on 3/2/15 at 2:10 P.M., the Director of Nursing indicated the resident was admitted on 11/5/14, and the facility used the physician progress note, dated 9/25/14, as the admitting history and physical and that the note did not indicate that the resident was free from tuberculosis or any other communicable diseases.</p> <p>During an interview on 3/4/15 at 9:30 A.M., the Director of Nursing indicated there was no policy available regarding a resident's need for a health statement.</p>		<p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set 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.</i></p> <p><b>1) Immediate action taken for those residents identified:</b></p> <p>Resident #6- Health statement indicating resident shows no evidence of tuberculosis in an infectious stage was obtained and placed in clinical record.</p> <p><b>2) How the facility identified other residents:</b></p> <p>An audit will be completed of all current resident clinical records to identify any other residents affected.</p> <p><b>3) Measures put into place/ System changes:</b></p> <p>All potential admissions will be screened prior to admission to ensure resident is free of infectious disease including tuberculosis.</p> <p>An audit will be completed on all new admission records within 72 hours and annually thereafter to ensure documentation of health statement indicating resident is</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 03/04/2015	
NAME OF PROVIDER OR SUPPLIER  APERION ESTATES PERU, LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 1200 KITTYHAWK DRIVE PERU, IN 46970			
(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			
	<p>2. On 2/27/15 at 1:30 P.M., record review indicated Resident #3's admission date to the facility was 10/18/12, and her diagnoses included but were not limited to: "...diabetes and heart attack...."</p> <p>Further review of the medical record indicated the resident's last office visit was 9/16/14, and did not include a statement that the resident was free of tuberculosis or other communicable diseases.</p> <p>During an interview on 3/2/15 at 2:15 P.M., the Director of Nursing indicated there was not a signed statement in the resident's chart indicating the resident is free from tuberculosis and other communicable diseases.</p> <p>3. The clinical record for Resident #6 was reviewed on 02/27/15 at 2:00 P.M. Resident #6 was admitted to the facility on 11/10/14 with diagnosis, including but not limited to hypertension and major depression.</p> <p>There was no health statement indicating Resident #6 was free from infectious diseases including tuberculosis.</p> <p>4. On 3/2/15 at 9:00 A.M., a review of the clinical record for Resident #4 was conducted. The record indicated the</p>		<p>free from infectious disease including tuberculosis is present.</p> <p>The Director of Nursing or designee will be responsible for oversight of these audits.</p> <p><b>4) How the corrective actions will be monitored:</b></p> <p>The results of these audits will be reviewed monthly x3 months, then quarterly x1 for a total of 6 months.</p> <p><b>5) Date of compliance: 4/3/15</b></p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 03/04/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  APERION ESTATES PERU, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1200 KITTYHAWK DRIVE PERU, IN 46970
---	---

(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
R 410 Bldg. 00	<p>resident was admitted on 7/11/2008. The resident's diagnoses included, but were not limited to: anxiety, aortic stenosis, hypertension and edema.</p> <p>An annual health assessment, with a statement indicating the resident had no evidence of tuberculosis was not located in the resident's clinical record.</p> <p>On 3/4/15 at 9:20 A.M., a current policy titled "Evaluation of Resident's Needs" dated 5/9/14, was received from the Administrator in Training, when she was asked for the annual health assessment policy. The policy indicated "...An evaluation of the Resident's needs will be completed on admission and at least every six (6) months thereafter...."</p> <p>During an interview, on 3/4/15 at 2:20 P.M., the Director of Nursing (DON) indicated she could not located an annual health assessment for Resident #4.</p> <p>410 IAC 16.2-5-12(e)(f)(g) Infection Control - Noncompliance (e) In addition, a tuberculin skin test shall be completed within three (3) months prior to admission or upon admission and read at forty-eight (48) to seventy-two (72) hours.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 03/04/2015	
NAME OF PROVIDER OR SUPPLIER  APERION ESTATES PERU, LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 1200 KITTYHAWK DRIVE PERU, IN 46970			
(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			
	<p>The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered and read.</p> <p>(f) For residents who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed within one (1) to three (3) weeks after the first test. The frequency of repeat testing will depend on the risk of infection with tuberculosis.</p> <p>(g) All residents who have a positive reaction to the tuberculin skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis.</p> <p>Based on record review and interview, the facility failed to provide a Mantoux (Tuberculosis skin test) prior or on admission to the facility. ( Resident #2)</p> <p>Finding includes:</p> <p>On 2/27/15 at 9:20 A.M., a review of the clinical record for Resident #2 was conducted. The record indicated the resident was admitted on 11/1/14. The resident's diagnoses included, but were not limited to: chronic back pain, mild mental retardation, diabetes and chronic obstructive pulmonary disease.</p> <p>The Annual TB (Tuberculosis) Testing Record, dated 11/3/15, indicated the resident received her Mantoux TB test on</p>	R 410	<p><b>R410</b></p> <p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set 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.</i></p> <p><b>1) Immediate action taken for those residents identified:</b></p> <p>Resident #2- Unable to correct deficiency cited for timeframe of</p>	04/03/2015			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 03/04/2015
NAME OF PROVIDER OR SUPPLIER  APERION ESTATES PERU, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1200 KITTYHAWK DRIVE PERU, IN 46970		
(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	
	<p>11/3/15. The test was given 2 days after her admission to the facility and did not include a recorded time the test was conducted.</p> <p>During an interview, on 2/27/15 at 9:30 A.M., the Director of Nursing (DON) indicated the test wasn't done upon admission because a nurse wasn't in the facility to administer the test on Saturday.</p> <p>On 3/2/15 at 11:30 A.M., the DON provided the current "Policy for Tuberculosis Testing of Residents", undated. The policy indicated "...It is the policy of this facility that all residents will be tested for tuberculosis upon admission and annually thereafter...."</p>		<p>mantoux testing. First and second step mantoux testing was completed and both tests were negative for TB.</p> <p><b>2) How the facility identified other residents:</b></p> <p>An audit will be completed of all current resident clinical records to identify any other residents affected.</p> <p><b>3) Measures put into place/ System changes:</b></p> <p>All new admissions will be reviewed within 72 hours of admission to ensure Mantoux/ TB skin testing was completed prior to or on admission to the facility.</p> <p>The Director of Nursing or designee will be responsible for oversight of these audits.</p> <p><b>4) How the corrective actions will be monitored:</b></p> <p>The results of these audits will be reviewed monthly x3 months, then quarterly x1 for a total of 6 months.</p> <p><b>5) Date of compliance: 4/3/15</b></p>		