| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155702 | A. BUILDING 00<br>B. WING | 12/21/2015 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| APERION CARE PERU | 1850 WEST MATADOR ST<br>PERU, IN 46970 |

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| F 0000<br><br>Bldg. 00 | This visit was for a Post Survey Revisit (PSR) to the Recertification and State Licensure Survey which resulted in an Extended Survey - Substandard Quality of Care completed on November 4, 2015.<br><br>This visit was in conjunction with the Investigation of Complaint IN00188514 and IN00188552.<br><br>Survey dates: December 15, 16, 17, 18 and 21, 2015<br><br>Facility number: 003130<br>Provider number: 155702<br>AIM number: 200386750<br><br>Census bed type:<br>SNF/NF: 54<br>Total: 54<br><br>Census payor type:<br>Medicare: 8<br>Medicaid: 41<br>Other: 5<br>Total: 54<br><br>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1. | F 0000 | | |

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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.

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| | Quality Review completed by 14454 on December 29, 2015. | | | |
| F 0224 SS=D Bldg. 00 | 483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN<br>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.<br>Based on observation, interview and record review, the facility failed to prevent an incident of verbal mistreatment by staff regarding a resident who was attempting to stand unassisted. This affected 1 out of 14 residents residing in the Touchstone (Dementia) Unit. (Resident #20)<br><br>Finding includes:<br><br>On 12/14/15 at 2:50 P.M., the Activity Assistant #12 was observed telling Resident #20 to sit down, using a loud aggressive tone, while she grabbed the back of the resident's pants and lower her to the chair.<br><br>On 12/21/2015 at 1:25 P.M., a review of the clinical record for Resident #20 was conducted. The record indicated the resident was admitted on 7/15/2015. The | F 0224 | **F 224**<br><br>**The facility requests paper compliance for this citation.**<br><br>*This Plan of Correction is the center's credible allegation of compliance.*<br><br>*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 provision of federal and state law.*<br><br>**1) Immediate actions taken for those residents identified:**<br><br>Resident #20 was immediately assessed for any negative | 01/20/2016 |

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| | MDS (Minimum Data Set) assessment, dated 11/2/15, indicated that the resident's BIMS (Brief Interview for Mental Status) score was 3, severely cognitively impaired. Resident #20's diagnoses included, but were not limited to; Parkinson's disease, restless leg syndrome, Alzheimer's, delirium due to known physiological condition and sleep disorder.<br><br>A care plan, dated 11/20/2015, indicated "...Intervene as necessary to protect the rights and safety of others. Approach/Speak in a calm manner. Divert attention. Remove from situation and take to alternate location as needed...."<br><br>On 12/18/15 at 2:20 P.M., the Administrator provided the policy titled, Abuse Prevention Program, Facility Policy, dated as reviewed on 1/1/2015, and indicated this was the policy currently used by the facility. The policy indicated, "This facility affirms the right of our residents to be free from abuse, neglect, misappropriation of resident property, corporal punishment, and involuntary punishment. This facility therefore prohibits mistreatment, neglect, or abuse of its residents, and has attempted to establish a resident sensitive and resident secure environment. The | | effects. None noted. Family and physician for Resident #20 were notified<br><br>**2) How the facility identified other residents:**<br><br>A. All residents in the Touchstone Terrace Unit were interviewed by staff to determine if they had been negatively affected. None noted.<br><br>**3) Measures put into place/systems changes:**<br><br>A. Activity Assistant #12 has been individually re-educated on responding to residents with dementia.<br><br>B. All licensed and non-licensed were re-educated on Abuse Policies, Procedures, and Prohibition, as well as approach with Dementia residents and reporting requirements<br><br>C. Additional training titled "Dementia: An Alternate Reality" and "Difficult Behaviors: Managing without Antipsychotics" | |

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| | purpose of this policy is to assure that the facility is doing all that is within its control to prevent occurrences of mistreatment, neglect, or abuse of our resident...."<br><br>3.1-27(b) | | has been held for staff and families<br><br>D. Management will be assigned Guardian Angel Rounds to observe residents and staff. Staff to observe resident/ staff interaction during rounds at least 3 times a week, at various times, and will be completed on a routine basis indefinitely.<br><br>E. Guardian Angel reviews, once complete, will be forwarded to the Administrator on a weekly basis and reviewed monthly during Aperion's Quality Assurance Meeting.<br><br>Any concerns identified will be addressed immediately and reported to Administrator and DON/ designee, and noted for further follow up, as merited.<br><br>The Administrator or designee will be responsible for oversight of these audits | |

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| | | | **4) How the corrective actions will be monitored:**<br><br>The results of these audits will be given to the Administrator weekly and reviewed by the Quality Assurance Committee at the monthly Quality Assurance Meeting for 6 months or until 100% compliance is achieved x3 consecutive months.<br><br>**5) Date of compliance: 01-20-16** | |
| F 0241<br>SS=D<br>Bldg. 00 | 483.15(a)<br>DIGNITY AND RESPECT OF INDIVIDUALITY<br>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.<br>Based on observation, interview and record review, the facility failed to ensure a residents dignity was maintained while she was resting in her bed during two of two observations. (Resident #41)<br><br>Finding includes:<br><br>On 12/16/2015 at 10:00 A.M., a review of the clinical record for Resident #41 | F 0241 | **F 241**<br><br>**The facility requests paper compliance for this citation.**<br><br>*This Plan of Correction is the center's credible allegation of compliance.*<br><br>*Preparation and/or execution of this plan of correction does not constitute admission or* | 01/20/2016 |

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| | was conducted. The record indicated the resident was admitted on 1/14/2015. The residents diagnoses included, but were not limited to; dementia with behavioral disturbance, aphasia, pseudobulbar affect, muscle weakness, anxiety disorder, post traumatic seizures and hypothyroidism.<br><br>On 12/17/2015 at 10:59 A.M., Resident #41 was observed lying in bed in her room, sideways with her right leg hanging off of the bed and her brief visible to residents and staff, in the dining room. The residents' roommate was observed attempting to cover the residents legs. Resident #41's daughter indicated the resident was exposed and could be seen at the nurses station. The daughter was further observed to enter the residents room and assist the resident back to bed. The ADON (Assist Director of Nursing) was observed to enter the residents room to assist.<br><br>On 12/17/2015 at 3:18 P.M., the resident was observed in her bed sideways with both feet on the floor and her brief was exposed to the dining area.<br><br>On 12/21/2015 at 9:20 A.M., the Administrator provided a policy titled, "TLC MANAGEMENT RESIDENT," undated, and indicted that this is the policy currently used at the facility. The | | *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 provision of federal and state law.*<br><br>**1) Immediate actions taken for those residents identified:**<br><br>Resident # 41 was assisted by staff to preserve her dignity<br><br>**2) How the facility identified other resident:**<br><br>No other residents were found to be identified.<br><br>All residents have the potential to be affected.<br><br>**3) Measures put into place/systems changes:**<br><br>A. Resident #41's care plan and Kardex was updated to reflect that when she is in bed, her privacy curtain should be pulled, as well as she should be wearing pants while in bed to help ensure her dignity. | |

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| | policy indicated "...(a) Dignity. The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality...."<br><br>This deficiency was cited on November 4, 2015. The facility failed to implement a systemic plan of correction to prevent recurrence.<br><br>3.1-3(t) | | B. Nursing staff were educated on care plan update for Resident #41 on by Director of Nursing.<br><br>C. Direct Care Staff including activity aides were re-educated on resident dignity by Director of Nursing.<br><br>**4) How the corrective actions will be monitored:**<br><br>All management staff will conduct Guardian Angel Rounds at least 3 times per week, at various times and observe residents for dignity and concerns. These audits will continue on an ongoing basis, indefinitely.<br><br>Any concerns identified will be addressed immediately and noted for further follow up, as merited.<br><br>The Administrator or designee will be responsible for oversight of these audits | |

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| | | | Results of these audits will be given to the Administrator weekly and reviewed by the Quality Assurance Committee at the monthly Quality Assurance Meeting for 6 months or until 100% compliance is achieved x3 consecutive months.<br><br>**Date of compliance: 1-20-16** | |
| F 0279 SS=D Bldg. 00 | 483.20(d), 483.20(k)(1)<br>DEVELOP COMPREHENSIVE CARE PLANS<br>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.<br><br>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.<br><br>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).<br>Based on interview and record review, the facility failed to initiated a care plan | F 0279 | **F 279** | 01/20/2016 |

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| | for a resident who required the use of a sleep aide for a diagnosis of insomnia for 1 of 3 residents reviewed. (Resident #4)<br><br>Finding includes:<br><br>On 12/16/2015 at 10:00 A.M., a record review of the clinical record for Resident #4 was conducted. The record indicated the resident was admitted on 09/18/2015. The residents diagnoses included, but were not limited to: muscle weakness, speech disorder, dysphagia, type 2 diabetes mellitus, aural vertigo, sleep disorder, adjustment disorder with depressed mood, cardiac murmur, hypertension, restless legs syndrome and anxiety disorder.<br><br>A physician's order, dated 10/6/15, indicated that Resident #4 was ordered to have a Melatonin (a sleep agent) tablet 3 milligrams at bedtime.<br><br>The MDS (Minimum Data Set) assessment, dated 11/3/15, indicated the resident had trouble falling or staying asleep.<br><br>Resident #4 did not have a care plan to address the resident's insomnia or the use of melatonin.<br><br>During an interview on 12/16/2015 at | | **The facility requests paper compliance for this citation.**<br><br>*This Plan of Correction is the center's credible allegation of compliance.*<br><br>*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 provision of federal and state law.*<br><br>**1) Immediate actions taken for those residents identified:**<br><br>1. Resident #4's careplans were updated to include a careplan for the use of melatonin for her insomnia<br><br>**2) How the facility identified other residents potentially affected:**<br><br>All residents that are receiving a sleep aide are identified as being at risk of being affected.<br><br>An audit of residents receiving sleep aids was conducted on December 18 and no other | |

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| | 12:41 P.M., the SSD (Social Service Director) indicated she had been looking over all the charts and she did not realize the medication was ordered or the resident had insomnia.<br><br>On 12/18/2015 at 10:45 A.M., the Unit Manager provided a policy titled "CARE PLANS PROTOCOL," undated, and indicted the policy was currently used by the facility. The policy indicated "...The care plan must be periodically reviewed and revised, and the services provided or arranged must be in accordance with each resident's written plan of care...." and "...The care plan should be revised on and on-going basis to reflect changes in the resident and the care the resident is receiving...."<br><br>This deficiency was cited on November 4, 2015. The facility failed to implement a systemic plan of correction to prevent recurrence.<br><br>3.1-35(a) | | residents were found to be affected.<br><br>**3) Measures put into place/systems changes:**<br><br>Nursing staff, Department Managers and Social Service Director will be re-educated on implementing and updating care plans.<br><br>All resident care plans will be reviewed by Interdisciplinary team within 7 days after MDS completion to ensure appropriate care plans are in place as identified. This process will be ongoing.<br><br>New orders will be reviewed at least 3 times per week to ensure care plan is implemented or updated as appropriate.<br><br>**4) How the corrective actions will be monitored:** | |

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| | | | The Director of Nursing or designee will review new admission assessments the next business day following admission to ensure that an interim care plan has been completed for identified risk areas.<br><br>The Director of Nursing or designee will audit at least 3 residents per week who have had an MDS completed in the prior 7 days to ensure that appropriate care plans are in place.<br><br>The Social Service Director or designee will audit all new orders for sleep aids on the next business day following the order receipt to ensure that a care plan has been completed for the use of this medication.<br><br>The results of these audits will be reviewed in the Quality Assurance meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months.<br><br>**5) Date of compliance: 1-20-16** | |
| F 0309 SS=D Bldg. 00 | 483.25<br>PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING<br>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and | | | |

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| | psychosocial well-being, in accordance with the comprehensive assessment and plan of care.<br>Based on observation, record review and interviews, the facility failed to ensure insulin medications were obtained timely and administered as ordered for 1 of 4 diabetics during a medication administration pass. (Resident #103)<br><br>Finding includes:<br><br>During an observation of a morning medication administration pass, on 12/17/15 at 9:10 A.M., LPN (Licensed Practical Nurse) #1 indicated she was not yet finished with the morning medication pass. She indicated she needed to "Levemir " (a type of insulin) to Resident #103, however the resident was in the restroom.<br><br>On 12/17/15 at 10:42 A.M., LPN #1 was queried regarding the Levemir insulin. She indicated she did not have access to the insulin for Resident #103 because it was locked in another medication cart and she could not locate the keys. The Director of Nursing (DON), Assistant Director of Nursing (ADON) and a Corporate Nurse RN #4 were observed trying to unlock the medication cart with various keys. | F 0309 | **F 309**<br><br>**The facility requests paper compliance for this citation.**<br><br>*This Plan of Correction is the center's credible allegation of compliance.*<br><br>*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 provision of federal and state law.*<br><br>**1) Immediate actions taken for those residents identified:**<br><br>Resident # 103 did not exhibit any complications related to not receiving her Levemir and sliding scale insulin. The resident's physician was notified regarding this occurrence.<br><br>**2) How the facility identified other resident:**<br><br>All residents receiving long and short acting insulins have the | 01/20/2016 |

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| | During an interview, on 12/17/2015 at 10:46 A.M., LPN #2, who took over job duties for LPN #1, indicated Resident #103 had not been given her 9:00 A.M. Levemir insulin dose nor her sliding scale Novolog.<br><br>On 12/17/2015 at 11:33 A.M., a maintenance employee utilized a drill to open the locked medication cart so nursing staff had access to the insulin for Resident #103. However, the missed dose of insulin was not administered and her blood sugar was not assessed regarding her possible need for the sliding scale Novolog insulin scheduled for 11:00 A.M.<br><br>On 12/17/15 at 11:40 A.M., LPN #2 indicated Resident #103 was in the main dining room eating lunch.<br><br>LPN #2 was observed from 10:30 A.M. thru 12:10 P.M., passing medications. LPN #2 was not observed to have administered the Levemir insulin nor did she obtain the resident's blood sugar for sliding scale Novolog insulin.<br><br>On 12/18/15 at 9:15 A.M., a review of the clinical record for Resident #103 was conducted. The record indicated the resident was admitted on 12/14/15. The resident's diagnosis included, but was not | | potential to be affected.<br><br>**3) Measures put into place/systems changes:**<br><br>1) LPN #1 is no longer employed at Aperion Care of Peru.<br><br>2) LPN #2 received re-education and disciplinary action relating to the incorrect documentation for Resident #103<br><br>3) Levemir and Humalog now available in the EDKs available at Aperion Care of Peru<br><br>4) Nurses will be re-educated on insulin administration, following physician orders, EDK use and drugs available within EDKs. Lists of contents of EDKS have been provided to all nurses stations.<br><br>**4) How the corrective actions will be monitored:**<br><br>DON or designee will audit all new admissions on following business day to ensure all medications available within the EDK have been given, as ordered. If it is found that medications were available and not given, DON/ designee to follow up with re-education and disciplinary action, as needed. | |

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| | 155702 | A. BUILDING 00<br>B. WING | 12/21/2015 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| APERION CARE PERU | 1850 WEST MATADOR ST<br>PERU, IN 46970 |

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| | limited to: diabetes.<br><br>The Admission insulin orders, dated 12/14/15, indicated the resident was to receive Levemir (insulin) 25 units subcutaneously two times per day with next dose due at 9:00 P.M., and Novolog 2 - 10 units subcutaneously 3 times a day before meals next dose due at 4:30 P.M.<br><br>The Medication Administration Record (MAR) indicated the resident received her first dose of Levemir insulin at the facility, on 12/15/15 at 5:00 P.M. The MAR indicated the resident had not received the 9:00 A.M. dose of Levemir. The MAR further indicated Novolog insulin per sliding scale (dosage determined by a checking the blood glucose level) three times a day, with a start date of 12/15/15. The sliding scale doses were written as: "... if 0-54 = call physician; 55-180 = 0; 181-200 = 4 units inject 4 units subcutaneous; 201-240 = 6 units inject 6 units subcutaneous; 241-280 = 8 units inject 8 units subcutaneous; 281-350 = 10 units inject 10 units inject 10 units subcutaneous; 351 + = 10 units inject 10 units and call physician...." The first time a blood sugar result was recorded was on 12/15/15 at 4:00 P.M. and the resident's blood sugar was 224 and 6 units of Novolog insulin was given | | The Director of Nursing/Designee will observe medication administration pass for at least 10 residents per week x30 days on varied different shifts to ensure medications are administered as ordered, when they are due. Observations will include at least 3 residents receiving short acting insulin per week x30 days. Medication pass observations will then be completed on at least 5 residents per week on varied shifts thereafter until 100% compliance is achieved x3 consecutive months.<br><br>The results of these audits will be reviewed in Quality Assurance meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months.<br><br>**5) Date of compliance: 1-20-16** | |

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| | subcutaneously. The MAR further indicated a dose of Levemir insulin was given on 12/17/15 at 10:40 A.M. The Levemir insulin was administered by LPN #2, indicated by her initials documented in the 9:00 A.M. time slot on the MAR.<br><br>During an interview, on 12/18/15 at 11:45 A.M., the ADON, LPN #2 indicated she did not administer the 9:00 A.M. dose of Levemir insulin to Resident #103 even though she accidentally documented the medication as given on 12/17/15 at 10:40 A.M.<br><br>During an interview, on 12/18/15 at 12:00 P.M., the Director of Nursing (DON) indicated she was not aware of any concerns specific to Resident #103's medications until yesterday 12/17/15. She further indicated the EDK (emergency drug kit) only contained regular insulin and 70/30 NPH (isphane insulin suspension - insulin injection combination) insulin.<br><br>3.1-37(a) | | | |

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| F 0312<br>SS=D<br>Bldg. 00 | 483.25(a)(3)<br>ADL CARE PROVIDED FOR DEPENDENT RESIDENTS<br>A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.<br>Based on observation, interview and record review, the facility failed to ensure nail care was provided for 1 of 3 residents reviewed for ADL (Activities of daily living) needs. (Resident #59)<br><br>Finding includes:<br><br>On 12/17/2015 at 10:08 A.M., a review of the clinical record for Resident #59 was conducted. The record indicated the resident was admitted on 7/29/2015. The diagnoses included, but were not limited to; Parkinson's disease, ataxia, difficulty in walking, muscle weakness, adjustment disorder with depressed mood and atrial fibrillation.<br><br>A care plan, dated 12/14/2015, indicated Resident #59's was to have his nail length checked, trimmed, and cleaned, on bath day and as necessary.<br><br>On 12/17/2015 at 10:05 A.M., Resident #59's nails were observed to be soiled and extended well past the tips of his fingers. | F 0312 | **F 312**<br><br>**The facility requests paper compliance for this citation.**<br><br>*This Plan of Correction is the center's credible allegation of compliance.*<br><br>*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 provision of federal and state law.*<br><br>**1) Immediate actions taken for those residents identified:**<br><br>Resident #59, nails were cleaned and trimmed.<br><br>**2) How the facility identified other resident:** | 01/20/2016 |

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| | During an interview on 12/17/2015 at 11:40 A.M., the ADON (Assistant Director of Nursing) indicated that Resident #59's nails needed to be trimmed and cleaned.<br><br>During an interview, on 12/17/2015 at 11:44 A.M., Resident #59 indicated that his fingernails needed to be trimmed. He held his hand up to show his fingernails were soiled and needed to be trimmed.<br><br>A shower schedule received from the Unit Manager on 12/18/2015 at 10:45 A.M., indicated Resident #59 was scheduled to have his showers on Tuesdays and Fridays.<br><br>On 12/18/2015 at 11:59 A.M., the DON (Director of Nursing) provided a policy titled, "NAIL CARE," dated 4/2005, and indicated this was the policy currently used at the facility. The policy indicated "...1. Good grooming includes quality nail care. 2. When nails are dirty they present a poor impression to others, and they collect and hide microorganisms underneath the nails. 3. Nails that are not kept filed can easily scratch residents, visitors, and staff members...."<br><br>This deficiency was cited on November 4, 2015. The facility failed to implement | | All resident's nails were assessed and cleaned/trimmed as needed.<br><br>**3) Measures put into place/systems changes:**<br><br>1) Nursing staff were re-educated on nail care to be provided with bathing/shower schedule and PRN. Nursing staff encouraged to observe residents' nails during all care, and fix concerns upon finding.<br><br>**4) How the corrective actions will be monitored:**<br><br>The Director of Nursing or designee will observe 20 residents per week during rounds on varied shifts x30 days, then 5 residents per week thereafter to ensure nail care is provided.<br><br>In addition to these audits, all management staff will conduct Guardian Angel Rounds at least 3 times per week, at various times and observe residents for nail cleanliness and length. These audits will continue on an ongoing basis, indefinitely.<br><br>Any concerns identified will be addressed immediately and noted for further follow up, as merited | |

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| | a systemic plan of correction to prevent recurrence.<br><br>3.1-38(a)(3)(E) | | The Director of Nursing or designee will be responsible for oversight of these audits<br><br>The results of these audits will be reviewed in the Quality Assurance meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months.<br><br>**5) Date of compliance: 1-20-16** | |
| F 0315 SS=D Bldg. 00 | 483.25(d)<br>NO CATHETER, PREVENT UTI, RESTORE BLADDER<br>Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.<br>Based on observation, interview and | F 0315 | | 01/20/2016 |

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| | record review, the facility failed to ensure a toileting assistance was provided as care planned for 1 of 3 residents reviewed for incontinence needs. (Resident #41)<br><br>Finding includes:<br><br>On 12/16/2015 at 10:00 A.M., a review of the clinical record for Resident #41 was conducted. The record indicated the resident was admitted on 1/14/2015. The residents diagnoses included, but were not limited to; dementia with behavioral disturbance, aphasia, pseudobulbar affect, muscle weakness, anxiety disorder, post traumatic seizures and hypothyroidism.<br><br>Resident #41's last documented bladder assessment was on 4/22/2015.<br><br>A careplan, dated 4/29/15, indicated that Resident #41 was incontinent of bladder with a pattern of incontinence and would benefit from a scheduled toileting program related to cognitively impaired. The interventions included but may not be limited to; allow ample time for voiding, assist to the bathroom per individualized schedule: toilet at scheduled times 7:00 A.M., 10:00 A.M., 1:00 P.M., 4:00 P.M., 7:00 P.M., assist with transfers, clothing adjustments and pericare during toileting and provide privacy. | | **F 315**<br><br>**The facility requests paper compliance for this citation.**<br><br>*This Plan of Correction is the center's credible allegation of compliance.*<br><br>*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 provision of federal and state law.*<br><br>**1) Immediate actions taken for those residents identified:**<br><br>Resident #41- A voiding diary has been completed, resident has been reassessed and the care plan and toileting program has been reviewed and updated to meet residents care needs.<br><br>**2) How the facility identified other residents potentially affected:**<br><br>All residents identified as incontinent according to the MDS have the potential to be affected. | |

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| | On 12/17/2015 at 9:51 A.M., Resident #41 was assisted to her room from the dining room by Certified Nursing Assistant (CNA) #6 and CNA #7. The CNA's were observed to transfer Resident #41 to her bed and check her for incontinence. The staff indicated the resident was dry and did not provide any further toileting assistance.<br><br>On 12/17/2015 at 11:04 A.M., Resident #41's daughter was observed to go into the residents room. The daughter indicated that the residents brief was soiled with urine and the pads under the resident were also soiled with urine. The ADON (Assistant Director of Nursing) was then observed to come into the residents room and offer assistance with changing the residents incontinence brief. The Residents daughter further indicated that Resident #41 is able to get up and use the toilet with assistance.<br><br>During an interview, on 12/17/2015 at 11:24 A.M., CNA #6 indicted indicated that the pads under the resident were soiled with urine and she removed the pads.<br><br>During an interview on 12/18/2015 at 9:55 A.M., CNA #8 indicated that staff are to transfer Resident #41 to the toilet | | An audit will be completed on all current residents to ensure the toileting plans for all residents are displayed on the Kardex.<br><br>**3) Measures put into place/systems changes:**<br><br>Nursing staff were re-educated on incontinent care/ toileting needs to be provided according to care plan/kardex.<br><br>The MDS/Restorative nurse will complete a bladder assessment on new admissions within 7 days of admission, then quarterly thereafter or with significant change in bladder continence.<br><br>**4) How the corrective actions will be monitored:**<br><br>The Director of Nursing or designee will observe 15 residents per week during rounds on varied shifts x30 days, then 10 residents per week thereafter to ensure incontinence care/ toileting needs are provided according to plan of care.<br><br>The Director of Nursing or designee will audit all new admissions and at least 3 residents per week who have had an MDS completed in the prior 7 days to ensure that a recent bladder assessment has been completed and care plans and toileting programs are in place as | |

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| | to urinate.<br><br>On 12/18/2015 at 10:45 A.M., the Unit Manager provided a policy titled, "TOILETING PROGRAM," dated 6/4/2012, and indicated that this is the policy currently used at the facility. The policy indicated "...2)Scheduled toileting - A behavioral technique that calls for scheduled toileting at regular intervals on a planned basis to match the residents voiding habits or needs. The goal is to keep the resident dry by telling them to void at regular intervals. Attempts are made to match the voiding intervals to the resident's natural voiding pattern. Using the information gathered during the voiding pattern data gathering, a scheduled voiding program is put in place. This is appropriate for residents who cannot toilet self well as severely cognitive impaired or the frail elderly. Scheduled voiding is timed voiding usually every 3 to 4 hours while awake. The routine may be schedules such as before and after meals and bedtime...."<br><br>This deficiency was cited on November 4, 2015. The facility failed to implement a systemic plan of correction to prevent recurrence.<br><br>3.1-41(a)(2) | | indicated.<br><br>The results of these audits will be reviewed in the Quality Assurance meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months.<br><br>**5) Date of compliance: 1-20-16** | |

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| F 0332<br>SS=D<br>Bldg. 00 | 483.25(m)(1)<br>FREE OF MEDICATION ERROR RATES OF 5% OR MORE<br>The facility must ensure that it is free of medication error rates of five percent or greater.<br>Based on observation, record review and interview, the facility failed to ensure a medication error of less than 5 percent (%) for 1 of 14 residents observed during a medication pass. Two (2) medication errors were observed during 30 opportunities for error in medication administration. This resulted in a medication error rate of 6.66%. The errors involved 1 resident. (Resident #103)<br><br>Findings include:<br><br>During an observation of a medication administration pass, on 12/17/15 at 9:10 A.M., LPN Licensed Practical Nurse) #1 indicated she was not finished with the morning medication pass. She indicated she needed to administer an intravenous antibiotic and "Levemir " (a type of insulin) to Resident #103, however the resident was in the restroom. | F 0332 | **F 332**<br><br>**The facility requests paper compliance for this citation.**<br><br>*This Plan of Correction is the center's credible allegation of compliance.*<br><br>*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 provision of federal and state law.*<br><br>**1) Immediate actions taken for those residents identified:**<br><br>Resident # 103 did not exhibit any complications related to not | 01/20/2016 |

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| | On 12/17/15 at 10:09 A.M., Resident #103 was observed seated on the edge of her bed and LPN #1 entered her room to administer the intravenous antibiotic and Resident #103 indicated she needed her inhaler first. She further stated she has used an inhaler for 10 years and she had it with her when she came but "someone" took it away and she had not had her inhaler medication since. She indicated she could not breath without it.<br><br>LPN #1 exited the room, went back to the medication cart and looked through the medication cart. The Medication Administration Record (MAR) indicated the resident was to receive a Combivent Aerosol 18-103 micrograms - 2 puffs four times a day for shortness of breath. LPN #1 indicated there was only albuterol in the EDK (emergency drug kit) and the pharmacy delivery person was still an hour away from the facility.<br><br>On 12/17/15 at 10:20 A.M., LPN #1 then left the unit and indicated she needed to "get her keys." She returned to the unit at 10:40 A.M. and hung the intravenous antibiotic for Resident #103.<br><br>On 12/17/15 at 10:42 A.M., LPN #1 was queried regarding the Levemir insulin. She indicated she did not have access to the insulin for Resident #103 because it | | receiving her Levemir and sliding scale insulin. The resident's physician was notified regarding this occurrence.<br><br>**2) How the facility identified other resident:**<br><br>All residents receiving long and short acting insulins have the potential to be affected.<br><br>**3) Measures put into place/systems changes:**<br><br>1) LPN #1 is no longer employed at Aperion Care of Peru.<br><br>2) LPN #2 received re-education and disciplinary action relating to the incorrect documentation for Resident #103<br><br>3) Levemir and Humalog now available in the EDKs available at Aperion Care of Peru<br><br>4) Nurses will be re-educated on insulin administration, following physician orders, EDK use and drugs available within EDKs. Lists of contents of EDKS have been provided to all nurses stations.<br><br>**4) How the corrective actions will be monitored:** | |

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| | was locked in another medication cart and she could not locate the keys. The Director of Nursing (DON), Assistant Director of Nursing (ADON) and a Corporate Nurse RN #4 were observed trying to unlock the medication cart with various keys.<br><br>During an interview, on 12/17/2015 at 10:46 A.M., LPN #2, who took over job duties for LPN #1, indicated Resident #103 had not been given her 9:00 A.M. Levemir insulin dose, the Combivent inhaler, nor her sliding scale Novolog.<br><br>On 12/17/2015 at 11:33 A.M., a maintenance employee utilized a drill to open the locked medication cart so nursing staff had access to the insulin for Resident #103. However, the missed dose of insulin was not administered and her blood sugar was not assessed regarding her possible need for the sliding scale Novolog insulin scheduled for 11:00 A.M.<br><br>On 12/17/15 at 11:40 A.M., LPN #2 indicated Resident #103 was in the main dining room eating lunch.<br><br>On 12/17/15, from 10:30 A.M. thru 12:10 P.M., LPN #2 was observed passing medications. LPN #2 was not observed to have administered the Levemir insulin, | | DON or designee will audit all new admissions on following business day to ensure all medications available within the EDK have been given, as ordered. If it is found that medications were available and not given, DON/ designee to follow up with re-education and disciplinary action, as needed.<br><br>The Director of Nursing/Designee will observe medication administration pass for at least 10 residents per week x30 days on varied different shifts to ensure medications are administered as ordered, when they are due. Observations will include at least 3 residents receiving short acting insulin per week x30 days. Medication pass observations will then be completed on at least 5 residents per week on varied shifts thereafter until 100% compliance is achieved x3 consecutive months.<br><br>The results of these audits will be reviewed in Quality Assurance meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months.<br><br>**5) Date of compliance: 1-20-16** | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 155702 | A. BUILDING 00<br>B. WING | 12/21/2015 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| APERION CARE PERU | 1850 WEST MATADOR ST<br>PERU, IN 46970 |

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| | administering the Combivent inhaler, nor did she obtain the resident's blood sugar for sliding scale Novolog insulin.<br><br>On 12/18/15 at 9:15 A.M., a review of the clinical record for Resident #103 was conducted. The record indicated the resident was admitted on 12/14/15. The resident's diagnoses included but were not limited to: status post subdural hematoma with craniotomy, a burr hole/drainage of the hematoma, diabetes and hypertension.<br><br>The Medication Administration Record (MAR) indicated the resident was to receive Levemir insulin 25 units subcutaneously twice a day at 9 A.M. and 5 P.M. The MAR further indicated Novolog insulin per sliding scale (dosage determined by a blood glucose test) at 7 A.M., 11:00 A.M. and 4:00 P.M. The MAR indicated the resident was to receive Combivent Aerosol 18-103 MCG/ACT 2 puffs inhaled orally four times a day for shortness of breath at 8 A.M., 12 P.M., 4 P.M. and 8 P.M.<br><br>During an interview, on 12/18/15 at 11:45 A.M., the ADON indicated she did not administer the 9:00 A.M. dose of Levemir insulin to Resident #103 even though she accidentally documented the medication as given on 12/17/15 at 10:40 | | | |

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| | A.M. LPN #2 further indicated the inhaler had been discontinued and she had obtained another order for an Albuterol inhalation treatment.<br><br>During an interview, on 12/18/15 at 12:00 P.M., the DON indicated she was not aware of any concerns specific to Resident #103's medications until yesterday 12/17/15. She further indicated the EDK (emergency drug kit) only contained regular insulin and 70/30 NPH (isophane insulin suspension - insulin injection combination) insulin.<br><br>This deficiency was cited on November 4, 2015. The facility failed to implement a systemic plan of correction to prevent recurrence.<br><br>3.1-25(b)(9)<br>3.1-48(c)(1) | | | |

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| F 0425<br>SS=D<br>Bldg. 00 | 483.60(a),(b)<br>PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH<br>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.<br><br>A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.<br><br>The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.<br>Based on observation, interviews and record review, the facility failed to ensure physician ordered medications were available timely for 1 of 14 residents observed during the medication administration pass. (Resident #103)<br><br>Finding includes:<br><br>During the an observation of a morning | F 0425 | **F 425**<br><br>**The facility requests paper compliance for this citation.**<br><br>*This Plan of Correction is the center's credible allegation of compliance.*<br><br>*Preparation and/or execution of this plan of correction does not constitute admission or* | 01/20/2016 |

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| | medication administration pass, on 12/17/15 at 9:10 A.M., LPN (Licensed Practical Nurse) #1 indicated she was not yet finished with the morning medication pass. She indicated she needed to administer "Levemir " (a type of insulin) to Resident #103 however the resident was in the restroom.<br><br>On 12/17/15 at 10:09 A.M., Resident #103 was observed seated on the edge of her bed and LPN #1 entered her room and Resident #103 indicated she needed her inhaler first. She further stated she has used an inhaler for 10 years and she had it with her when she came but "someone" took it away and she had not had her inhaler medication since. She indicated she could not breath without it.<br><br>LPN #1 exited the room, went back to the medication cart and looked through the cart. The Medication Administration Record (MAR) indicated the resident was to receive a Combivent Aerosol (ipratropium bromide/albuteral) 18-103 micrograms (mcg) 2 puffs four times a day for shortness of breath. LPN #1 indicated there was only Albuterol in the EDK (emergency drug kit) and the pharmacy delivery person was still an hour away from the facility.<br><br>On 12/17/15 at 10:42 A.M., LPN #1 was | | *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 provision of federal and state law.*<br><br>**1) Immediate actions taken for those residents identified:**<br><br>Resident # 103 did not exhibit any complications related to not receiving her Levemir and sliding scale insulin. The resident's physician was notified regarding this occurrence.<br><br>**2) How the facility identified other resident:**<br><br>All residents receiving long and short acting insulins have the potential to be affected.<br><br>**3) Measures put into place/systems changes:**<br><br>1) LPN #1 is no longer employed at Aperion Care of Peru.<br><br>2) LPN #2 received re-education and disciplinary action relating to the incorrect documentation for Resident #103 | |

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| | queried regarding the Levemir insulin. She indicated she did not have any access to the insulin for Resident #103 because it was locked in another medication cart and she could not locate the keys. The Director of Nursing (DON) and LPN #3 and a Corporate Nurse, RN #4 were noted trying to unlock the medication cart with various keys.<br><br>On 12/17/2015 at 11:33 A.M., a maintenance employee utilized a drill to open the locked medication cart so nursing staff had access to the insulin for Resident #103. However, the missed dose of insulin was not administered and her blood sugar was not assessed regarding her need for the sliding scale Novolog insulin scheduled for 11:00 A.M.<br><br>On 12/17/2015 at 10:46 A.M., during an interview, LPN #2, who took over job duties for LPN #1, indicated Resident #103 had not been given her Levemir insulin dose, scheduled for 9:00 A.M., her sliding scale Novolog and her Combivent inhaler yet this morning. LPN #2 indicated she was going to call the physician and request a Nebulizer (albuterol) treatment for Resident #103 since the Combivent inhaler was not available. | | 3) Levemir and Humalog now available in the EDKs available at Aperion Care of Peru<br><br>4) Nurses will be re-educated on insulin administration, following physician orders, EDK use and drugs available within EDKs. Lists of contents of EDKS have been provided to all nurses stations.<br><br>**4) How the corrective actions will be monitored:**<br><br>DON or designee will audit all new admissions on following business day to ensure all medications available within the EDK have been given, as ordered. If it is found that medications were available and not given, DON/ designee to follow up with re-education and disciplinary action, as needed.<br><br>The Director of Nursing/Designee will observe medication administration pass for at least 10 residents per week x30 days on varied different shifts to ensure medications are administered as ordered, when they are due. Observations will include at least 3 residents receiving short acting insulin per week x30 days. Medication pass observations will then be completed on at least 5 residents per week on varied | |

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| | On 12/17/15 at 11:40 A.M., LPN #2 indicated Resident #103 was in the main dining room eating lunch.<br><br>LPN #2 was observed from 10:30 A.M. to 12:10 P.M., passing medications and she was not observed to have administered the Combivent inhaler or the Levemir insulin.<br><br>On 12/18/15 at 9:15 A.M. a review of the clinical record for Resident #103 was conducted. The record indicated the resident was admitted on 12/14/15. The resident's diagnoses included but were not limited to: status post subdural hematoma with craniotomy, a burr hole/drainage of the hematoma, diabetes and hypertension.<br><br>The medications, ordered on admission for Resident #103, included but were not limited to:<br>-Levemir (insulin) 25 units subcutaneous 2 times per day<br>-Novolog (insulin) 2 - 10 units subcutaneous 3 times a day before meals.<br>-Norvasc (antihypertensive) 5 mg orally daily<br>-Daptomycin (antibiotic) 400 mg intravenous daily<br>-Ertapenem Sodium (antibacterial)1 gram intravenous daily<br>-Levetiracetam (Keppra / | | shifts thereafter until 100% compliance is achieved x3 consecutive months.<br><br>The results of these audits will be reviewed in Quality Assurance meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months.<br><br>**5) Date of compliance:**<br>**1-20-16** | |

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| | anticonvulsant)) 750 mg orally bid<br>-Lisinopril (antihypertensive) 20 mg tablet 40 mg daily<br>-Pantoprazole (Protonix / reduces stomach acid) 40 mg before breakfast<br>-Albuterol Sulfate (bronchodilator) 1-2 puffs inhaler every 4 hours as needed<br><br>An Infectious Disease Consultation, dated 12/12/15, indicated the resident was diagnosed with an acute urinary tract infection. The physician had ordered both Daptomycin and Ertapenem Sodium to be given for 10 days intravenously.<br><br>The Medication Administration Record (MAR) for Resident #103 indicated Resident #103's blood sugar was not assessed until the 4:00 P.M. on 12/15/15. The resident's blood sugar was 224 and she received 6 units of Novolog insulin. In addition, she did not receive her 9:00 A.M. dose of Levemir ordered on 12/15/15. According to the MAR the resident did not receive the intravenous antibiotics, Ertapenem Sodium until 12/16/15 nor the Daptomycin 400 mg (milligrams) intravenously daily until 12/17/15 . The resident did not receive the Levetricetam (keppra) an anticonvulsant medication until the 5:00 P.M. dose on 12/16/15. She did not receive her Lisinopril, Norvasc, or Protonix medication until 12/16/15. | | | |

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| | During an interview, on 12/18/15 at 11:45 A.M., the ADON (Assistant Director of Nursing), LPN #2 indicated she did not administer the 9:00 A.M. dose of Levemir insulin to Resident #103 even though she accidentally documented the medication as given on 12/17/15 at 10:40 A.M. LPN #2 further indicated the inhaler had been discontinued and she had obtained another order for an Albuterol inhalation treatment.<br><br>During an interview, on 12/18/15 at 12:00 P.M., the Director of Nursing indicated she was not aware of any concerns specific to Resident #103's medications until yesterday 12/17/15.<br><br>This deficiency was cited on November 4, 2015. The facility failed to implement a systemic plan of correction to prevent recurrence.<br><br>3.1-25(a) | | | |

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| F 0465 SS=E Bldg. 00 | 483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON<br>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.<br>Based on observation, interviews and record review, the facility failed to provide a safe and clean environment related to, a strong urine odor in the dementia unit, holes in the walls of resident restrooms, paint in poor repair on doors, around door trim and walls and peeling paint on a restroom floor. This had the potential to affect 4 of 20 residents residing on the South hallway, 7 of 20 residents residing on the West hallway, and 14 of 14 residents residing on the Touchstone dementia unit.<br><br>Findings include:<br><br>On 12/17/15 from 10:00 A.M. to 11:00 A.M., an environmental tour was conducted with a maintenance employee, the Housekeeping Supervisor and the Administrator, during which the following was observed:<br><br>1. West Hallway:<br><br>At 10:00 A.M., Room 408, the bathroom walls were observed to have 16 separate holes the size of a pencil eraser. | F 0465 | **F 465**<br><br>**The facility requests paper compliance for this citation.**<br><br>*This Plan of Correction is the center's credible allegation of compliance.*<br><br>*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.*<br><br>**1) Immediate actions taken for those residents identified:**<br><br>West Hall | 01/20/2016 |

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| | At 10:05 A.M., Room 409, the bathroom walls were observed to have multiple holes the size of a pencil eraser.<br><br>At 10:10 A.M., Room 401, the bathroom walls had 10 holes the size of a pencil eraser.<br><br>2. South Hallway:<br><br>At 10:15 A.M., Room 137, scrapes and deep gouges were observed on the door frame surrounding the bathroom door.<br><br>At 10:20 A.M., Room 117, scrapes in the paint were observed on the bathroom door and the door frame.<br><br>At 10:25 A.M., Room 118, in the resident's bathroom an uncovered bed pan was observed on the floor of the shower, a urinal with no lid was hanging on the back of the toilet with a brown substance observed in the bottom of the urinal.<br><br>3. Touchstone Dementia Unit:<br><br>At 10:30 A.M., Room 200, the bathroom floor tile under the toilet and the tile on the 2 walls surrounding the toilet had dark green peeling paint observed. At this | | Room 408- The holes in bathroom walls have been placed on work order to completed by 1/20/16.<br><br>Room 409- Holes in bathroom wall have been placed on work order to be completed by 1/20/16.<br><br>Room 401- Holes in bathroom walls have been place on work order to be completed by 1/20/16.<br><br><u>South Hallway</u><br><br>Room 117&137- Scrapes and gouges on the bathroom door and door frame repaired and paint touched up have been placed on work order to be completed by 1/20/16.<br><br>Room 118- bed pan was removed from the shower, Urinal without lid was replaced, patient was given urinal with lid and removed from behind the toilet.<br><br><u>Touchstone Dementia unit</u><br><br>Room 200- Peeling paint from tiles under the toilet and 2 walls in the bathroom have been placed on work order to be completed by 1/20/16.<br><br>Dementia unit will be walked through 5 days a week and any environment concerns will be addressed on an ongoing basis | |

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| | time a form titled Maintenance Room Inspection, dated 12/10/15, was reviewed and indicated resident room number 200 the items that need repaired N/A (not applicable). Date to be completed N/A.<br><br>During an interview, on 12/17/15 at 10:35 A.M., the Housekeeping Supervisor indicated the Maintenance Supervisor used a paint thinner to remove the paint on the tile under the toilet in Room 200, she indicated the paint thinner absorbed into the grout and made the paint peel worse, she further indicated no further attempts to remove the paint had been made.<br><br>At 10:40 A.M., the entire Dementia unit had a strong prevalent urine odor.<br><br>At 10:50 A.M., the vinyl covered chairs in the television lounge and the dining area had a urine odor. The dining room chairs had a brown sticky substance on the backs and arms of the chairs.<br><br>During an interview, on 12/17/15 at 11:00 A.M., the Housekeeping Supervisor indicated the residents bathroom floors and the dining room floors are cleaned daily and the chairs are cleaned monthly or sooner if nursing staff alert her the chairs need to be cleaned. She further indicated the urine odor could | | After the completion of painting audits in the dementia unit, painting concerns observed will be completed by 1/20/16<br><br>Urine smell in the carpet on Touchstone is being address on an ongoing basis by an outside carpet cleaning company. Cleaning will be scheduled on a monthly basis. An initial cleaning has been completed and will resume in February. Carpet concerns identified between scheduled commercial cleanings will be addressed by the housekeeping department.<br><br>Furniture cleanings in Touchstone will be completed on a biweekly basis. Urine smell in furniture will be addressed also on an as needed basis by in house staff.<br><br>South Hall central bathroom has been cleaned and paint touched up around door and door frame will be completed by 1/20/16. | |

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| | be from a male resident that urinates in various areas of the dementia unit. She indicated the housekeeping staff spot clean when the nursing staff alert her regarding the area the male resident urinates in.<br><br>During an interview, on 12/17/15 at 11:05 A.M., Employee #10 indicated his supervisor is presently on vacation so he contacted him by phone and was advised phone quotes from several painting businesses were obtained to repaint. Employee #10 indicated none of the quotes are in writing at this time. Employee #10 further indicated maintenance staff are responsible to repair and fill in the holes in the walls and repair the scrapes in the door frames and do touch up painting before the contracted paint company comes into paint. He indicated he would start repairing the holes in the walls today.<br><br>During an interview, on 12/17/15 at 12:05 P.M., the Administrator indicated he obtained a copy of a written quote for repairs that was approved by corporate but there is no definite start date for the repairs.<br><br>This deficiency was cited on November 4, 2015. The facility failed to implement a systemic plan of correction to prevent | | **2) How the facility identified other residents:**<br><br>Audit will be completed of resident rooms and units to identify any other environmental concerns. Audit will be in process by 1/20/16<br><br>**3) Measures put into place/ System changes:**<br><br>Staff have been educated regarding process for completing work order and placing in maintenance mailbox when environment concerns are observed is in need of repairs.<br><br>**4) How the corrective actions will be monitored:**<br><br>Maintenance Director will develop a log and schedule to complete | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155702 | A. BUILDING 00<br>B. WING | 12/21/2015 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| APERION CARE PERU | 1850 WEST MATADOR ST<br>PERU, IN 46970 |

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|---|---|---|---|---|
| | recurrence.<br><br>3.1-19(f) | | inspection and repairs on at least 5 resident rooms or resident common areas per week until all are completed. Inspection of resident areas will be completed at least semi-annually for routine maintenance and upkeep thereafter.<br><br>The results of these audits will be reviewed in Quality Assurance Meeting monthly until 100% compliance is achieved x3 consecutive months.<br><br>**5) Date of compliance: 1-20-16** | |