STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155702	A. BUILDING 00 B. WING	06/22/2017

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

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F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00232992 and IN00232308. Complaint IN00232992 - Substantiated. No deficiencies related to the allegations are cited. Complaint IN00232308 - Substantiated. Federal/State deficiencies related to the allegations are cited at F282. Survey dates: June 20, 21 and 22, 2017 Facility number: 003130 Provider number: 155702 AIM number: 200386750 Census bed type: SNF/NF: 67 Total: 67 Census payor type: Medicare: 9 Medicaid: 54 Other: 4 Total: 67 This deficiency reflects 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 was completed on June 26, 2017.			
F 0282 SS=D Bldg. 00	483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. Based on record review and interview, the facility failed to follow the physician's medication orders and provide 3 of 3 residents their medications timely and as ordered. (Resident B, Resident C and Resident D) Findings include: 1. During an interview, on 6/21/17 at 11:22 A.M., Resident B indicated a couple nights ago, when LPN (Licensed Practical Nurse) #2 was working, he got his bed time (8:00 P.M.) medications late, around 1:30 A.M. On 6/21/17 at 12:40 P.M., a review of the clinical record for Resident B was conducted. The resident's diagnoses included, but were not limited to: Parkinson's Disease, paranoid	F 0282	Complaint Survey 6/22/2017 **F 282** ***Aperion Care Peru requests paper compliance for this one citation.*** *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.* **Immediate action taken for those**	07/06/2017

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	schizophrenia and sleep disorder. A 5-Day MDS (Minimum Data Set) Assessment, dated 6/2/17, indicated the resident's BIMS (Brief Interview for Mental Status) score was 15, cognitively intact. A care plan, dated 3/8/17, indicated the resident had trouble sleeping and anxiety. The interventions included, but were not limited to: administer medications, observed for adverse side effects, document and report to the medical doctor. The physician orders indicated the resident was to receive Tylenol PM 500/25 milligrams (mg) by mouth at bedtime for insomnia, vistaril 75 mg by mouth at bedtime for insomnia and lorazepam 0.5 mg. BID (twice a day) by mouth for anxiety. The MAR (Medication Administration Record) for June 2017, indicated on 6/15/17 and 6/19/17 the resident's evening/before bedtime medications (Tylenol PM, vistaril and lorazepam) were left blank on the MAR. (No nurse signature/initials signifying the medications were administered as ordered.)		**residents identified:** Residents "B", "C", "D"- Care plans, physician orders, medication and treatment orders were reviewed. Physician notified of medications not signed out on MAR. **How will the facility identify other residents potentially affected.** All resident medication and treatment administration records for the last 30 days were reviewed to identify any other residents affected. **Measures put in place/systems changed** Licensed nurses completed in-service for proper medication administration and documentation in the resident's clinical record. **How will the corrective action be monitored?** The Director of Nursing and/or designee will audit all resident Medication and Treatment records 3 times per week for 4 weeks, then 5 resident records per week for 8 weeks, and 3 resident records per week thereafter. The results of these audits will be reviewed in Quality Assurance Meetings monthly for 6 months or	

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	2. On 6/21/17 at 10:50 A.M., Resident C was observed on the dementia unit. The resident was dressed and sitting in a common area with his hospice nurse. The resident was alert but not oriented to place or time and not interviewable. On 6/21/17 at 12:00 P.M., a review of the clinical record for Resident C was conducted. The record indicated the resident was admitted on 1/4/17, with a re-admission on 5/4/17. The resident's diagnoses included, but were not limited to: dementia, insomnia and schizophrenia. The 30 day MDS (Minimum Data Set) Assessment, dated 6/1/17, indicated the resident's BIMS score was 0 (severe dementia) with behavioral symptoms occurring 1-3 days a week. A care plan, dated 10/13/16, indicated the resident had the potential for aggressive behaviors related to his dementia and schizoaffective disorder. Another care plan indicated the resident had impaired cognitive function and impaired thought process related to his dementia. The interventions included, but were not limited to: administer medications as ordered. Monitor and document for side effects and effectiveness of medications.		until 100% compliance is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendation to revise the plan of correction as indicated. **Date of Compliance:** July 6, 2017	

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	A Behavior/Mood Charting form, dated 6/20/17, indicated the resident was physically aggressive, displayed anger with self/others and was agitated. The physician orders indicated the resident was to receive divalproex sodium (Valproic Acid) delayed release 250 mg by mouth at bedtime for dementia with behaviors, trazodone 50 mg by mouth at bedtime for insomnia and Tylenol 650 mg 4 times a day for pain. The MAR, for June 2017, indicated on 6/8/17, 6/13/17, and 6/14/17 the resident's evening and before bedtime medications (Valproic Acid, trazodone and Tylenol) were left blank, no nurse's signature/intials on the MAR, to indicate medication was administrated as ordered. 3. On 6/21/17 at 11:35 A.M., Resident D was observed on the dementia unit. He was standing at the nurses station talking with staff members. He had a loud voice and was resistive to directions from the staff, but complied to sit in the common area, until lunch would be served. The resident was alert and oriented to self only and not interviewable. On 6/22/17 at 1:00 P.M., a review of the clinical record for Resident D was			

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	conducted. The resident's diagnoses included, but were not limited to: Alzheimer's disease, agitation, delusional, hypertension, sleep disorder, hyperlipidemia and diabetes. The 60 day MDS Assessment, dated 3/16/17, indicated the resident's BIMS score was 3 (severe dementia) and had wandering behaviors 1-3 days during the 7 day assessment period. A Behavior/Mood Charting form indicated the resident had behaviors on 6/1/17, 6/14/17, 6/18/17 and 6/19/17. The behaviors included verbal aggression, physical aggression and wandering. The 6/19/17 behavior occurred at 3:45 P.M. The resident's care plans indicated the resident had depression, a mood problem related to an anxiety disorder and the potential to display aggressive behaviors. The interventions for the care plans were to administer the resident's medications as ordered and to monitor/document for the medications side effects and effectiveness. The physician orders indicated the resident was to receive ativan 1 mg by mouth in the evening for anxiety, atvorvastatin calcium 10 mg by mouth at			

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	6:00 P.M. for hyperlipidemia, donepezil 10 mg by mouth daily at 6:00 P.M., sertraline 100 mg at 6:00 P.M. for generalized anxiety disorder/impulse control, losartan potassium 100 mg by mouth twice a day for hypertension, quetiapine furnarate 50 mg by mouth twice a day for psychosis. The MAR, for June 2017, indicated on 6/15/17, and 6/19/17 the resident's evening (6:00 P.M. and 8:00 P.M.) medications, which included ativan, atvorvastatin calcium, donepezil, sertraline, losaran potassium and quetiapine were not given as ordered. The nurse's signature and/or initials indicating she had given the medications was blank. On 6/22/17 at 9:45 A.M., the Director of Nursing (DON) provided a current policy titled "Medication Administration", dated 6/2014. The policy indicated "...2. All medication administration must be done by qualified, licensed nurses. The nurse is responsible for the preparation, administering accuracy and supporting documentation of all medications being administered...6. All medications must be administered within one hour before or one hour after the assigned pass time. On 6/22/17 at 1:55 P.M., the DON indicated there was no documentation			

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	found to explain why Resident B, Resident C and Resident D did not receive their medications on the dates and times in question. This Federal tag relates to complaint IN00232308 3.1-35(g)(2)			