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	07/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE PERU	1850 WEST MATADOR ST 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
F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00233785 and IN00235783. Complaint IN00233785 - Unsubstantiated due to lack of evidence. Complaint IN00235783 - Substantiated. Federal/State deficiencies related to the allegations are cited at F257. Unrelated deficiency is cited. Survey dates: July 20 and 21, 2017 Facility number: 003130 Provider number: 155702 AIM number: 200386750 Census Bed Type: SNF/NF: 69 Total: 69 Census Payor Type: Medicare: 8 Medicaid: 55 Other: 6 Total: 69 These deficiencies reflect State Findings cited in accordance with 410 IAC	F 0000	Aperion Care, Peru requests paper compliance for these citations. *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.*	

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.

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	07/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE PERU	1850 WEST MATADOR ST 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
	16.2-3.1. Quality Review was completed on July 26, 2017.			
F 0257 SS=E Bldg. 00	483.10(i)(6) COMFORTABLE & SAFE TEMPERATURE LEVELS (i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81 degrees F. Based on observation, interview and record review, the facility failed to maintain comfortable temperature levels for 4 of 5 units in the facility and had the potential to effect all 48 residents on those units. Finding include: On 7/20/17 at 4:00 P.M. thru 4:20 P.M., an initial walk through was conducted on each of the facility's units. The units on the east side were observed and were warmer than the west side of the building. Fans were in use in the North and South hallways and in some of the resident's room. A cart with fluids and ice was in the hallway. The dementia unit had a fan at the nurses station.	F 0257	Aperion Care, Peru requests paper compliance for these citations. *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 identified:** Residents residing in the following rooms were given a choice, to relocate to another area of the facility or stay in their room as long as the warmth was not a negative	07/21/2017

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	07/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE PERU	1850 WEST MATADOR ST 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
	On 7/20/17 at 4:30 thru 5:00 P.M., resident room temperatures were obtained with the Maintenance Director with the following results: North Unit Room 109 81.5 degrees Room 113 84 degrees Room 115 84 degrees Room 121 82.5 degrees Room 112 81 degrees South Unit Room 125 82.5 degrees Room 127 82.5 degrees Room 129 78 degrees Room 135 80 degrees Memory/Touchstone Unit Room 202 81 degrees Room 205 82.5 degrees Room 208 81 degrees On 7/20/17 at 5:15 P.M., the Maintenance Director provided multiple forms titled "Building Temperatures" and were dated 5/5/17 thru 7/20/17. The 7/20/17 form indicated the temperatures in the building at 8:00 A.M., ranged from 68 degrees to 80 degrees. The Maintenance Director indicated the facility was dealing with an air conditioner problem. He provided work orders from 5/16, 5/17, and 6/14/17 and		impact on their well-being. Room 109 Room 113 Room 115 Room 121 Room 112 Room: 125 Room: 127 Room: 129 Room: 135 Room: 202 Room: 205 Room: 208 All residents residing in these rooms opted not to relocate at this time; however, they understood from a clinical stand point if the need would warrant for them to move, they would at that time. **How will the facility identify other residents potentially affected:** Facility temperatures are checked and documented daily every 2 hours, through-out the facility for the initial findings on July 21, 2017 through August 7, 2017. **Measures put in place/systems changed:** The facilities Director of Maintenance and/or Environmental Services and/or Administrator will complete daily rounds checking temperatures in resident's rooms and all common areas. If the area	

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	07/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE PERU	1850 WEST MATADOR ST 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
	indicated the company had been out to facility, parts needed ordering and had to wait several weeks for the parts. The parts came in, but again needed special fittings to finish the job. During an interview, on 7/20/17 at 6:15 P.M., the Administrator indicated she was concerned about the room temperatures on Tuesday, however the Maintenance Director had reported no temperatures over 81 degrees. The Administrator said she was out of the facility on Wednesday due to meeting, out of town. She called the facility and was assured the temperatures were under 81 degrees. On Thursday she stopped and bought fans for the facility as the weather report indicated a hot day. She indicated residents had been asked if they wanted to change to a cooler room, however no one wanted to change rooms. The Administrator indicated there was no policy regarding the facility's room temperatures. This Federal tag related to complaint IN00235783. 3.1-19(h)		temperature is above the maximum of 81 degrees, the resident will have the choice of facility providing a fan and/or portable AC unit, or the resident may wish to relocate to another area of the facility, the nursing department will assess residents for indication excessive heat if nursing deems the resident needs to be relocated, the facility will act accordingly. Wall thermometers were mounted to common areas and hallways for staff to have a temperature quick reference. **How will the corrective action be monitored:** The facility will continue with daily temperature checks, until AC unit repairs are made. The findings will be communicated to Aperion Management, in addition, the audits will be reviewed in Quality Assurance Meetings monthly for 6 months, The QA Committee will identify any trends or patterns and make recommendation to revise the plan of correction as indicated.	

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	07/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE PERU	1850 WEST MATADOR ST 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
F 9999 Bldg. 00	3.1-13 ADMINISTRATION AND MANAGEMENT (w) In facilities that are required under IC 12-10-5.5 to submit an Alzheimer's and dementia special care unit disclosure form, the facility must designate a director for the Alzheimer's and dementia special care unit. The director shall have an earned degree from an educational institution in a health care, mental health,, or social service profession or be a licensed health facility administrator. The director shall have a minimum of one (1) year work experience with dementia or Alzheimer's residents, or both, within the past five (5) years. Persons serving as a director for an existing Alzheimer's and dementia special care unit at the time of adoption of this rule are exempt from the degree and experience requirements. The director shall have a minimum of twelve (12) hours of dementia-specific training within three (3/ months of initial employment as the director of the Alzheimer's and dementia special care unit and six (6) hours annually thereafter to: (1) meet the needs or preferences, or both, of cognitively impaired residents; and	F 9999	The facility has designated the facilities Administrator as the current Memory Care Director. **Measures put in place/systems changed:** All staff assigned to our Memory Care Environment and facility managers will complete a minimum of 6 hours of Dementia training. All new hires starting August 1, 2017 will be required to complete Dementia training during their initial orientation. **How will the corrective action be monitored:** Administrator along with DON will audit employee files to confirm completion of Dementia course(s). **Date of Compliance:**August 20, 2017	08/20/2017

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	07/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE PERU	1850 WEST MATADOR ST 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
	(2) gain understanding of the current standards of care for residents with dementia. (X) The director of the Alzheimer's and dementia special care unit shall do the following: (1) Oversee the operation of the unit. (2) Ensure that: (A) personnel assigned to the unit receive required in-service training; and (B) care provided to Alzheimer's and dementia care unit residents is consistent with; (i) in-service training; (ii) current Alzheimer's and dementia care practices; and (iii) regulatory standards. This state rule was not met as evidenced by: Based on observations, interview and record review, the facility failed to ensure there was a designated director for the dementia unit, this had the potential to effect the 14 residents on the dementia unit called Touchstone. Finding includes: During the initial walk through, on 7/20/17 from 4:10 P.M. thru 4:20 P.M., the dementia unit called Touchstone was observed. CNA (Certified Nursing Aide)			

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	07/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE PERU	1850 WEST MATADOR ST 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
	# 4 was walking with a resident. The resident was behind CNA #4 and holding her hand. CNA #4 never spoke or made eye contact with the resident as they walked. Several other residents were walking aimlessly throughout the unit. Approximately 8 residents were in a common area with a TV on, but no one watching it. A staff member indicated she was an activity aide but no formal activity was occurring. On 7/21/17 at 11:00 A.M. through 11:40 A.M., Resident B was observed on the dementia unit. She was observed sitting in the common area, with the TV on. The resident was observed to nod off to sleep. At 11:45 A.M., Resident B was awaken by two aides who encouraged her to stand and walk to her room. The resident was taken to the restroom. At no time was the resident informed of what the aides wanted to do with her. The resident was then observed to be escorted to the dining room and she remained seated until she was served her meal. An Activiity Aide indicated the resident had participated earlier in a game of "corn hole" and folding some clothing items. On 7/21/17 at 11:00 A.M. thru 11:40 A.M., Resident D was observed on the dementia unit wandering in the hallways. At one point he went to his room and			

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	07/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE PERU	1850 WEST MATADOR ST 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
	shut the door. After a few minutes he returned to hallways, walked around for a few minutes then sat in a chair down from the common area, where other residents were sitting. The resident's room was observed to have a large puddle of yellow substance on the floor, CNA #3 indicated the resident must have urinated on the floor and called housekeeping to clean the area. The resident remained in hallway until he was told to go to the dining area for lunch. He was observed to walk directly to the dining area and take a seat with two other residents. The meal was served at 11:50 A.M. On 7/21/17 at 1:50 P.M., two staff members, LPN (Licensed Practical Nurse) #2 and CNA #3, on the dementia unit both indicated the DON (Director of Nursing) was the dementia unit coordinator. At 1:55 P.M., the DON indicated she was unaware of who the dementia unit coordinator was and she would "check on that". At 1:58 P.M., the DON indicated a Corporate Representative #5 was the dementia unit's doordinator and she was rarely in the building.			

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	07/21/2017

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