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	01/10/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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 a Recertification and State Licensure Survey. Survey dates: January 3, 4, 5, 8, 9 and 10, 2018 Facility number: 00003130 Provider number: 155702 AIM number: 200386750 Census Bed Type: SNF/NF: 65 Total: 65 Census Payor Type: Medicare: 4 Medicaid: 58 Other: 3 Total: 65 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality Review was completed on January 17, 2018.	F 0000	Please accept the following as the facilities credible allegation of compliance. The plan of correction does not constitute any guilt or liability by the facility and submitted only in response to the regulatory requirement.	
F 0600 SS=D	483.12(a)(1) Free from Abuse and Neglect			

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

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Bldg. 00	§483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; [illegible]	F 0600	**Corrective Action Implemented:** The facility followed the Abuse Policy and Federal / State Regulations requirement. The allegation was reported timely and local law enforcement notified. Employees was suspended during investigation and terminated upon facility substantiating abuse allegation. **How will the facility identify other residents having the potential to be affected by the deficient practice**? All residents have the potential to be affected by	02/09/2018

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			the same alleged deficient practice. Social Service will interview current alert and oriented residents to ensure no abuse/force as occurred. **The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not occur:** All Staff will be re-in serviced on the facilities Abuse Policy, Residents Rights and Staff Burn Out. Social Service will meet with resident council by February 9, 2018 to review Abuse Policy and Resident Rights along with staff burnout. Social Service will review quarterly the Abuse Policy Residents Rights and Staff Burn Out. New staff will continue to receive abuse training, Residents Rights and Staff Burn Out during orientation. All Staff in-services will be conducted on a needed basis and yearly. Social Services/designee will interview alert and oriented	

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			residents quarterly to ensure no alleged abuse has occurred. Social Service will interview 5 alert and oriented residents weekly times 3 months then 5 residents monthly times 9 months to ensure no alleged abuse has occurred. Facility will continue to follow Abuse protocol and report accordingly to State and Federal guidelines. **Quality Assurance Plans to monitor facility performance to make sure that corrective actions are achieved / permanent:** **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. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.**	

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F 0604 SS=D Bldg. 00	483.10(e)(1); 483.12(a)(2) Right to be Free from Physical Restraints §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. Based on interview and record review, the facility failed to ensure a resident with dementia was not restrained in a wheelchair. This deficiency affected 1 of 1 residents	F 0604	Please accept the following as the facilities credible allegation of compliance. The plan of correction does not constitute any guilt or	02/09/2018

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	reviewed for restraints. (Resident 118) Finding includes: The clinical record was reviewed on 1/9/18 at 9:00 a.m., and indicated Resident 118 had diagnoses that included but were not limited to, Alzheimer's disease, cognitive communication deficit, delusional disorder, anxiety disorder, and atherosclerotic heart disease. A review of Incident Number 232, provided by the Interim Executive Director, on 1/9/18 at 2:00 p.m., indicated on 12/21/17 it was reported to the Executive Director, that 2 staff held Resident 118 down, then applied a gait belt for restraint. The follow up investigation, dated 12/28/17, indicated, "Alleged staff remained on suspension, pending investigation...The facility was able to validate through interview statements and through investigation that both Certified Nursing Assistants (CNAs), used inappropriate force to keep the resident in the chair and applied a gait belt around her waist to restrain her after the resident demonstrated what the CNAs described as restless uncontrollable behavior placing the resident at risk for injury. Police were notified...."		liability by the facility and submitted only in response to the regulatory requirement, this finding was part of the initial reporting of claim #232. Claim # 232 was reviewed upon annual survey, surveyor agreed with investigation and substantiated facility's findings. **Corrective Action Implemented:** The facility followed the Abuse Policy and Federal / State Regulations requirement. The allegation was reported timely and local law enforcement notified. Employees was suspended during investigation and terminated upon facility substantiating abuse allegation. Facility investigation concluded that a gait belt was used to restrain resident in a chair using force. **How will the facility identify other residents having the potential to be affected by the deficient practice**?	

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	On 1/9/18, at 9:39 A.M., an interview with the Regional Vice President of Operations, indicated Incident Number 232 was investigated and substantiated by the acting Executive Director, and action was taken to terminate the involved employees. On 1/9/18 at 1:35 P.M, the ADON (Assistant Director of Nursing) provided the policy titled "Restraints," dated 11/7/17, and indicated the policy was the one currently used by the facility. The policy indicated "...Purpose: To ensure that each resident is to attain and maintain his/her highest practicable well-being in an environment that prohibits the use of restraints for discipline or convenience and limits restraint use to circumstances in which the resident has medical symptoms that warrant the use of restraints... Guidelines... 4. Restraint assessments are performed at a minimum with the initial application... and change in the resident's condition which affects how the resident responds to current treatment. 5. Less restrictive measures such as pillows, pads, low beds, removable lap trays, or behavior plans together with appropriate exercise shall be considered prior to use of more restrictive restraints...." 3.1-26(a)		All residents have the potential to be affected by the same alleged deficient practice. Facility is a restraint free facility and no tolerance for physical restraints / force of any kind on residents. **The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not occur:** All Staff will be re-in serviced on the facilities Abuse Policy and Proper usage of a Gait Belt by February 9 2018. New staff will continue to receive Abuse Training \ Gait Belt training during orientation to ensure gait belt is not used for a restraint. Social Services / Designee will conduct rounds, and Department Heads will continue Angel Rounds 5 x a week. Any concerns will be addressed at end of day stand down meeting; and or upon notification from Staff, Residents and or Visitors. Any allegation will be	

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			investigated immediately. **Quality Assurance Plans to monitor facility performance to make sure that corrective actions are achieved / permanent: The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved times 3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.**	
F 0656 SS=D Bldg. 00	483.21(b)(1) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable			

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	objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) 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 §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.			
	Based on interview and record review, the	F 0656	**1) Immediate actions taken for those residents identified:**	02/09/2018

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	facility failed to ensure a plan of care was developed and implemented for a urinary tract infection diagnosis being treated with an IV (intravenous) antibiotics for 1 of 16 residents reviewed for care plans. (Resident 215) Findings include: A clinical record review was completed on 1/5/18 at 3:05 P.M., and indicated Resident 215 was re-admitted on 12/29/17. Diagnosis included, but were not limited to: urinary tract infection, hypertension, diabetes, heart failure, and hypokalemia. A physician's order, dated 12/30/17, indicated Resident 215 was to have Ertapenem (an antibiotic medication) 1 Gram daily via IV (intravenously) for 7 days. The Admission/Re-admission Observation form, dated 12/29/17 at 20:05 (8:05 P.M.), indicated under section R, interim care plans pulled to care plan, #4. infection care plans focus of IV medications and urinary tract infection was left blank. Review of all current care plans for Resident 215 indicated there were no care plans addressing the current infection and the use of the IV/antibiotics.		Resident # 215 care plan was updated to include infection, IV and IV antibiotics **2) How the facility identified other residents:** All residents with change in condition such as infection, antibiotic use, IV, skin conditions, etc. were reviewed to ensure the plan of care was updated. Care plans will be reviewed for accuracy according to the MDS schedule. **3) Measures put into place/ System changes:** Nursing staff will be re-educated on Care plans and the components needed to be in care plan **4) How the corrective actions will be monitored:** MDS coordinator will audit at least 3 care plans per week to ensure they reflect the current care of the resident. The DON or designee will review physician orders and documentation for change in	

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	During an interview on, 1/5/18 at 3:43 P.M., the Director of Nursing indicated there should be a care plan for the UTI (urinary tract infection) and the I.V. On 1/10/18 at 11:13 A.M., the Administrator provide the policy titled," Comprehensive Care Plan", and indicated the policy was the one currently used by the facility. The policy indicated... " The care plan should be revised on an ongoing basis to reflect changes in the resident and the care that the resident is receiving...." 3.1-35(b)(1)		condition at least 3 times per week and update plan of care accordingly to reflect any changes. 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. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on review of facility [illegible]	F 0689	**1) Immediate actions taken for those residents identified:**	02/09/2018

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	[redacted]		Resident #216 fall interventions have been reviewed and plan of care updated. **2) How the facility identified other residents:** Current residents who have had a fall in the last 60 days were reviewed to ensure the recommended interventions are in place and noted on the plan of care. **3) Measures put into place/ System changes:** Nursing staff will be re-educated on Care plans and the components needed to be sure all interventions are in place **4) How the corrective actions will be monitored:** Audits will be performed on at least 3 residents identified as at risk for falls per week by Don/Designees to ensure fall interventions are in place. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved	

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			x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	
F 0755 SS=D Bldg. 00	483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. 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. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and			

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	§483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Based on interview and record review, the facility failed to follow the facility pharmacy policy related to missed medication doses for 1 of 5 residents reviewed for unnecessary medications (Resident 44). Finding includes: During an interview on 1/8/18 at 9:24 A.M., Resident 44 indicated he asked for two tylenol around 5:30 A.M. and the nurse said she did not have time to get them. He indicated he was supposed to get a pain pill at 4:00 A.M. and was told the pain pill was not available so he did not receive it at that time but did receive one around 6:00 A.M.. A clinical record review was completed on 1/8/18 at 9:45 A.M., and indicated Resident 44 was admitted to the facility on 9/8/15. His diagnoses included, but were not limited to malformation of coronary vessels, anxiety disorder, COPD, muscle weakness, stage 3 chronic kidney disease, morbid obesity, heart failure, muscle wasting, chronic pain, recurrent major depressive disorder with	F 0755	**1) Immediate actions taken for those residents identified:** Resident #44 had no negative effects from missed medication. **2) How the facility identified other residents:** A medication audit will be completed to ensure medications are available. Medication records will be reviewed for the last 30 days to identify other residents with missed doses of medication, and physician notified as appropriate if change in condition or adverse effects are noted. **3) Measures put into place/ System changes:** Licensed nurses will be re-educated regarding administering medications as ordered, documentation on the MAR and procedure for unavailable meds including use of EDK box and back up pharmacy to obtain medication, and physician notification if not able to obtain medication. **4) How the corrective**	02/09/2018

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	psychotic symptoms, psychosis, adjustment disorder with depressed mood, sleep disorder, difficulty in walking, diabetes and tremor. A quarterly MDS (Minimum Data Set) assessment, dated 12/6/17, indicated Resident 44 had a BIMS (Brief Interview for Mental Status) of 15, cognitively intact and had mild pain occasionally. A care plan problem, dated 12/2/17, indicated the resident had pain related to arthritis and a previous farming accident as a young man. Interventions for this problem included, administer medications as ordered and encourage resident to ask for pain medication at the first sign of unrelieved pain. A care plan problem, dated 12/2/17, indicated the resident had depression. An intervention for this problem included, administer medications as ordered. A care plan problem, dated 12/2/17, indicated the resident had GERD (gastroesophageal reflux disease). An intervention for this problem included, give medications as ordered. A current order, dated 11/29/17, indicated		**actions will be monitored:** The DON or designee will audit medication administration records at least 3 times per week to ensure medications were administered and documented as ordered and appropriate procedure followed for unavailable medications. The DON or designee will audit medication supply for at least 3 residents per week to ensure medications are available per physician order. 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. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	

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	the resident received acidophilus (a probiotic medication used for the treatment of GERD) one tablet by mouth one time a day every other day for digestive health. A current order, dated 9/27/17, indicated the resident received Brintellix (an antidepressant medication) 20 mg (milligrams) by mouth one time a day for depressive episodes. A current order, dated 12/19/16, indicated the resident received Percocet (a pain medication) 7.5-325 mg by mouth every four hours for chronic pain. A "Medication Administration Record," dated 11/1/17 - 11/30/17 indicated the resident did not receive a 4:00 A.M. dose of Percocet on 11/1/17, did not receive a 5:00 A.M. dose of acidophilus on 11/9/17 and did not receive a 5:00 A.M. dose of Brintellix on 11/15/17. A "Medication Administration Record," dated 12/1/17 - 12/31/17 indicated the resident did not receive a 6:00 A.M. dose of Brintellix on 12/9/17. A "Medication Adminstration Record," dated 1/1/18 - 1/8/18 indicated the resident did not receive a 4:00 A.M. dose of			

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	155702	A. BUILDING 00 B. WING	01/10/2018

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	Percocet on 1/8/17. A progress note, dated 1/8/18, indicated, "...awaiting pharmacy...." During an interview on 1/9/18 at 9:58 A.M., the DON (Director of Nursing) indicated the resident should have received the missed medication. On 1/9/18 at 12:30 P.M., the Administrator provided the policy titled "LTC [Long Term Care] Facilities Receiving Pharmacy Products and Services from Pharmacy," dated 1/1/13, and indicated the policy was the one currently used by the facility. The policy indicated "...Procedure 1. Upon discovery that facility has an inadequate supply of a medication to administer to a resident, facility staff should immediately initiate action to obtain the medication from pharmacy. If the medication shortage is discovered at the time of medication administration, facility should immediately take the actions specified in Sections 2 or 3 of this Policy... 3. If a medication shortage is discovered after normal pharmacy hours: 3.1 A licensed facility nurse should obtain the ordered medication from the Emergency Medication Supply. 3.2 If the ordered medication is not available in the Emergency Medication Supply, the licensed facility			

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	nurse should call pharmacy's emergency answering service and request to speak with the registered pharmacist on duty to manage the plan of action. Action may include: 3.2.1 Emergency delivery; or, 3.2.2 Use of an emergency (back-up) third party pharmacy. 4. If an emergency delivery is unavailable, facility nurse should contact the attending physician to obtain orders or directions. 5. If the medication is unavailable from pharmacy or a third party pharmacy, and cannot be supplied from the manufacturer, facility should obtain alternate physician/prescriber orders, as necessary... 7. If facility nurse is unable to obtain a response from the attending physician/prescriber in a timely manner, facility nurse should notify the nursing supervisor and contact facility's Medical Director for orders/direction, making sure to explain the circumstances of the medication shortage... 8. When a missed dose is unavoidable, facility nurse should document the missed dose and the explanation for such missed dose on the MAR [Medication Administration Record]... and in the nurse's notes per facility policy. Such documentation should include the following: 8.1 A description of the circumstances of the medication shortage; 8.2 A description of pharmacy's response upon notification; and 8.3 Action(s) taken...."			

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	3.1-25(a)			
F 0921 SS=E Bldg. 00	483.90(i) Safe/Functional/Sanitary/Comfortable Environ §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation and interview, the facility failed to ensure rooms and halls were maintained in a safe, comfortable, and sanitary manner. This had the potential to affect the residents in 2 of the 3 facility units (Garden-Memory Care, and Unit 100 Hall). Findings include: During an initial facility tour, on 1/3/18, at 1:00 p.m., the following was observed: Chipped paint to wall heaters and walls in Rooms 113, 116, 137, and 206. Room 116 had 4 screw holes on the the South wall by bathroom door and 2 screw holes on the West wall. Room 117-2 with broken door to bottom of free standing closet. Room 121 had window casing area chipped through drywall and missing paint. Room 133 with chipped and missing paint behind the room door. Room 201 was observed with a dirty adult diaper	F 0921	**1) Immediate actions taken for those residents identified:** Rooms 113, 116, 137 and 206 chipped paint and screw holes were repaired. Room 117 closet broken door is repaired. Room 121 window casing repaired. Room 133 chipped paint repaired. Room 201 dirty brief was removed, bathroom tiles cleaned and repaired. Room 203 toilet repaired and floor cleaned. Room 204,206 and exit doors black substances was removed. Room 206 privacy curtain replaced. Room 208 broken closet door repaired. Garden shower room drywall repaired. Exit door ice buildup on 200 unit cleared. **2) How the facility identified other residents:** All residents could be affected **3) Measures put into place/ System changes:** Environmental educated on observing and reporting of areas	02/09/2018

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	laying on the bathroom floor. 4 wall tiles to the right of the bathroom sink were broken and covered with white sticky debris. Room 203 with the toilet off the wall, for repair, and bathroom floor covered with water. Room 204 had a 4 cm (centimeter) area of black substance growing to the North side of the window, on the lower right side. Room 206 had a 10 cm by 4 cm area of black substance growing to the North side of the window, on the lower right side, no privacy curtain to bed 1. Room 208 had a broken door to bottom of free standing closet. Garden Unit shower room had large gouges in the drywall to next to the tub, the exit door to the outdoors had a dark substance growing around the metal frame of the door where condensation was collecting. Large areas of ice had built up to the bottom of the exit door 12 inches up the corners of the door. On 1/8/18, during a facility tour with Director of Environment (DOE) he acknowledged the observations detailed in the initial building tour, and indicated the facility had identified chipped walls in halls, and were in the process of repainting. He indicated the concerns found in the initial building tour should be repaired, and were not homelike. During an interview, on 1/9/18 at 10:30 A.M., the Regional Vice President indicated mold and ice were found around the exit door in The Garden unit and needed to be removed.		which require improvement. Maintenance educated regarding need to identify environmental issues while completing other tasks in the building. **4) How the corrective actions will be monitored:** Audit will be done by environmental director/designee 5 rooms per week looking for environmental concerns. Maintenance director or designee will audit 5 areas each week for environmental concerns, these will include outdoors and common areas. 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. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **5) Date of compliance: 2/09/18**	

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	A request for a facility maintenance policy was requested, but no policy was provided. 3.1-19(f)			