STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	01/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION ESTATES PERU, LLC	1200 KITTY HAWK DRIVE, PERU, , 46970

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES...	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION...	(X5) COMPLETION DATE
R 0000	INITIAL COMMENTS This visit was for the Investigation of Complaints IN00451120, IN00451001 and IN00449584. Complaint IN00451120 - No deficiencies related to the allegations are cited. Complaint IN00451001 - State deficiencies related to the allegations are cited at R0052. Complaint IN00449584 - State deficiencies related to the allegations are cited at R0052. Survey date: January 17 & 21, 2025 Facility number: 013327 Residential Census: 26 This State Residential Finding is cited in accordance with 410 IAC 16.2-5. Quality Review completed on 1/27/2025	R 0000		

R 0052	Residents' Rights - Offense 410 IAC 16.2-5-1.2(v)(1-6) (v) Residents have the right to be free from: (1) sexual abuse; (2) physical abuse; (3) mental abuse; (4) corporal punishment; (5) neglect; and (6) involuntary seclusion. Based on observation, interview and record review, the facility failed to ensure residents were free from mental abuse and corporal punishment related to intimidation and lack of freedom to make food choices and receive menued desserts when dining at the facility. This noncompliance resulted in numerous residents feeling humiliated and deprived of their meal choices. (Residents C, L, F, N, J and M) Findings include: 1 .During an interview on 1/17/25 at 12:44 P.M., an anonymous Staff Member 2 indicted she had some concerns regarding the Administrator. She indicated she had heard the Administrator telling resident's if they did not eat all their food,	R 0052	I What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; All residents, if able, will be allowed to select their own choices on the menu and it will be served by the dietary dept. II How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents have the potential to be affected by this alleged deficient practice. The administrator is no longer with the facility. III What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;	02/14/2025

	they would not get dessert. She indicated the Administrator had made dietary staff serve Resident N carrots and the resident did not like carrots. She then heard the Administrator tell Resident N if she did not eat the carrots, she would not get anything else to eat. Staff Member 2 indicated the Administrator had been going through the resident's menu choices and had marked out certain items the residents had requested. Staff Member 2 indicated Resident C ordered cottage cheese twice a day and dietary staff had been instructed by the Administrator not to serve it to him. She indicated the kitchen had plenty of cottage cheese and she did not know why the Administrator would change the resident's menu choices. Staff Member 2 provided menus, for some of the residents, titled, "Today's Menu" which indicated Resident C had cottage cheese requested but it had been crossed out on his menu, Resident M had grilled cheese requested but it had been crossed out and the word "hold back" on the dessert. Staff Member 2 indicated the server was to "hold" the dessert until residents finished the rest of their meal. Resident J's menu had milk written beside each meal, however milk for lunch and dinner had been crossed off. Staff Member 2 indicated the Administrator had instructed		All staff will be inserviced on abuse and resident rights. IV How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; The administrator or designee will interview 2 staff members and 5 residents weekly x 4 weeks then 2 staff members and 2 residents weekly ongoing. The results of these audits will be reviewed in Quality Assurance Meeting monthly x12 months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	

the Dietary Staff that residents could only be served milk for breakfast and no juice or milk was to be provided for other meals, even if requested by the resident for the lunch and dinner meals. Resident F's menu had cottage cheese requested but it had been crossed out.

During an interview, on 1/17/25 at 1:16 P.M., anonymous Staff Member 3 indicated he had observed some incidents in the dining room regarding the Administrator's demeanor with some of the residents. He indicated on one occasion, he had witnessed the Administrator telling Resident P, who usually ate only 1/2 of what was served on her plate, that she bet the resident would not eat everything and the resident had looked distressed by the Administrator's comment. Staff Member 3 indicated Resident F who usually ate everything on his plate and would lick his plate clean had been embarrassed when the Administrator was overheard telling the resident "That was disgusting" referring to the resident licking his plate. He indicated the Administrator had been crossing out menued and requested food items the residents had circled on their menus.

During an interview, on 1/17/25 at 1:42 P.M., the anonymous Staff Member 4 indicated it was

the Administrator who had crossed through the food items the residents had chosen for their meals. The Administrator had also instructed staff to "hold" some of the desserts until the resident had eaten all of the rest of their meals.

2. During an interview, on 1/17/25 at 10:53 A.M., Resident C indicated each day at lunch time, he received a menu for the next day. He circled what he wanted for each meal but the drinks were not included on the menu form. He indicated he circled cottage cheese as he wanted to receive cottage cheese with his lunch and dinner meals. He indicated he had not received the cottage cheese for almost 2 weeks, even though he continued to mark it as requested. He indicated he was not sure why but he thought it had something to do with an incident that had occurred in the dining room a few weeks ago. He indicated when he did not eat everything he had requested, the Administrator told him if he did not eat everything on his plate, she would not "give me anymore food". He indicated this made him feel like a child. He indicated he had requested cottage cheese on the menu everyday since then, but he had not received the cottage cheese. Resident C indicated he had marked cottage cheese as

a request on his menu for the lunch and dinner meal on 1/17/2025.

On 1/17/25 from 11:19 AM though 12:01 P.M., the lunch meal was observed being served. Resident C had not been served cottage cheese and when approached, the server she indicated it had been crossed out on the resident's menu. Observation of Resident C's "Today's Menu" form for the lunch and dinner meal indicated Resident C's cottage cheese request had been crossed out.

On 1/21/25 at 12:40 P.M., a review of the clinical record for Resident C was conducted. The resident's diagnoses included, but were not limited to; cerebral palsy, history of lumbar fracture and spinal cord compression.

A Service Plan, dated 11/4/24, indicated the facility would provide 3 meals, 7 days a week and " ...Resident will have the opportunity to select their meal items ...."

3. During an interview on 1/17/25 at 2:34 P.M., Resident L indicated she could only have one glass of milk a day and only at breakfast per the Administrator. She indicated the Administrator had "put her down" calling her negative, her exact words to her were "You are so negative." Resident L

indicated it just was not right and made her feel bad. Resident L indicated she quit asking for milk at her other meals.

On 1/21/25 at 1:04 P.M., a review of the clinical record for Resident L was conducted. The resident's diagnoses included, but were not limited to; osteoarthritis and age related osteoporosis and history of cerebral infarction due to an embolism. Resident L was alert and oriented.

A Service Plan, dated 11/7/24, indicated the facility provided 3 meals 7 days a week and " ...Resident will have the opportunity to select their meal items ...."

4. A form titled "Today's Menu", for 1/17/25 for Resident F was observed. Resident F's request for cottage cheese as a lunch side and dinner side had been crossed out.

During an interview, on 1/21/25 at 10:42 A.M. Resident F indicated he "loved anything dairy" and had been requesting cottage cheese everyday but he had not been receiving it with his meals and he did not know why. He indicated "maybe they don't have it". He also liked milk with every meal, but only received mild at breakfast and he was not sure why that

happened either. After viewing the "Today's Menu" for 1/17/2025, he confirmed the menu was the one he had filled out but he indicated he had not cross out the cottage cheese and just verbally told the dietary server what he wanted to drink, but when he asked for milk, he had been told he could only have it with breakfast. .

On 1/21/25 at 12:34 P.M., a review of the clinical record for Resident F was conducted. The resident's diagnoses included, but were not limited to; diabetic, dementia and osteoporosis with history of a pathological fracture of left humerus. Resident alert and oriented to person place and time.

A service plan, dated 12/2/24, indicated facility would provide 3 meals 7 days a week and " ...resident will have the opportunity to select their meal items ...."

5. A form titled "Today's Menu", for 1/17/25, indicated Resident N's krispie bar for lunch and pears for dinner had the words "Hold Back" written beside them and "1/2" written beside the meal selections for lunch and dinner.

On 1/21/25 at 9:48 A.M., an interview was conducted with Resident N and her sister Resident Q. Resident N was

alert to self only, however, Resident Q indicated Resident N did not write on her menu "1/2 or hold back". Resident Q indicated her sister had been served her dessert later than she was served her dessert, but she was unsure why this had occurred. She believed the "1/2" meant her sister received smaller portions as she had observed her sister meal had smaller portion than her meal.

On 1/21/25 at 2:03 P.M., a review of the clinical record for Resident N was conducted. The resident's diagnoses included, but were not limited to; osteoporosis and anemia.

A current service plan, dated 11/29/24, indicated the facility provided 3 meals 7 days a week and " ...Resident will have the opportunity to select their meal times ...."

6. A form titled "Today's Menu", for 1/17/25 for Resident J, indicated Resident J"s milk request had been crossed out for lunch and dinner, but not for breakfast.

During an interview on 1/21/25 at 10:50 A.M. Resident J indicated he had written milk on his menu, but only received milk with his breakfast meal. Resident J confirmed he did not mark out milk on his 1/17/25 menu. Resident J indicated he

would not have marked it out because he wanted it.

On 1/21/25 at 12:54 P.M., a review of the clinical record for Resident J was conducted. The resident's diagnoses included, but were not limited to; diabetic, dementia, anxiety, bipolar disorder and vitamin D deficiency. Resident J was alert to self and place, but very heard of hearing.

A current service plan, dated 12/17/24, indicated the facility provided 3 meals 7 days a week and " ...Resident will have the opportunity to select their meal times ...."

7. A form titled "Today's Menu", for 1/17/25 for Resident M indicated the krispie bar request had an added note to "hold back" and the grilled cheese request had been crossed out.

During an interview, on 1/21/25 at 10:55 A.M. Resident M indicated he had been told by the Administrator he could not have his dessert until he ate all of his meal so sometimes he did not receive a dessert. He confirmed the 1/17/25 menu was his and he had circled his choices for each meal, but he had not written the words "hold back" on the form. He indicated he had circled grilled cheese and had not crossed it out but may have made a mistake

because he had also circled "Turkey pot pie" and he understood he could not have the pot pie and a toasted cheese. He indicated he really wanted the toasted cheese and not the pot pie, but no one had asked him which entree he wanted as far as he could remember, so he just ate what they gave him.

On 1/21/25 at 12:54 P.M., a review of the clinical record for Resident M was conducted. The resident's diagnoses included, but were not limited to; dementia, schizophrenia, and partial loss of teeth.

A current service plan, dated 11/26/24, indicated the facility provided 3 meals 7 days a week and " ...Resident will have the opportunity to select their meal times ...."

During an interview/observation of lunch meal, on 1/17/25 at 12:07 P.M., anonymous Staff Member 2 indicated Resident C and Resident F had received cottage cheese with their lunch meal today and residents who always had their desserts "held" had received them when everyone else received them today only. However, milk was not served because that was a directive from the Administrator instructing staff that milk was to be served only with the breakfast meal.. No milk or juice

was allowed to be served during the lunch or supper meals. Staff Member 2 indicated there were no residents who received special diets or had diet restrictions.

During an interview, on 1/21/25 at 2:38 P.M., the Director of Nursing (DON) indicated the Administrator had been reviewing the resident's menus and she was aware the Administrator had been making changes on them by marking out some of the requested items. She indicated she had no idea as to why the Administrator had been doing that but indicated some residents, like Resident L, would mark cottage cheese but then would not eat all of it or any of it, so the Administrator would cross it off. The DON had no idea where the notion of "no milk during lunch or supper" came from because when she first worked at the facility, the residents even had chocolate milk as a choice along with white milk at each meal.

On 1/17/25 at 12:09 P.M., the Administrator provided a policy titled, "Abuse Neglect and Misappropriation of Resident Property", undated, and indicated the policy was the one currently used by the facility. The policy indicated "...Abuse: The willful infliction of injury, unreasonable confinement, intimidations or punishment with

resulting physical pain or mental anguish. This also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental and psychosocial well-being...Verbal Abuse: The use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance...Mental Abuse: This includes, but is not limited to, humiliation, harassment, threats of punishment or deprivation...."

On 1/21/25 at 11:08 A.M., the Administrator provided a policy titled, " Resident Rights", dated 8/23/17 with a reviewed date of 1/4/19, and indicated the policy was the one currently used by the facility. The policy indicated "...Purpose: To promote the exercise of rights for each resident, including any who face barriers (such as communication problems, hearing problems and cognitive limits) in the exercise of these rights. A resident, even though determined to be incompetent, should be able to assert these rights based on his or her degree of capability...Exercising rights means that residents have autonomy and choice, to maximum extent possible about how they wish to live their everyday lives and receive care, subject to the facility rules, as

long as those rules do not violate a regulatory requirement. The facility will not hamper, compel, treat differentially, or retaliate against a resident for exercising his/her rights...."

This State Residential finding relates to Complaints IN00451001 and IN00449584.

Based on observation, interview and record review, the facility failed to ensure residents were free from mental abuse and corporal punishment related to intimidation and lack of freedom to make food choices and receive menued desserts when dining at the facility. This noncompliance resulted in numerous residents feeling humiliated and deprived of their meal choices. (Residents C, L, F, N, J and M)

Findings include:

1 .During an interview on 1/17/25 at 12:44 P.M., an anonymous Staff Member 2 indicted she had some concerns regarding the Administrator. She indicated she had heard the Administrator telling resident's if they did not eat all their food, they would not get dessert. She indicated the Administrator had made dietary staff serve Resident N carrots and the resident did not like carrots. She then heard the Administrator tell Resident N if she did not eat the

carrots, she would not get anything else to eat. Staff Member 2 indicated the Administrator had been going through the resident's menu choices and had marked out certain items the residents had requested. Staff Member 2 indicated Resident C ordered cottage cheese twice a day and dietary staff had been instructed by the Administrator not to serve it to him. She indicated the kitchen had plenty of cottage cheese and she did not know why the Administrator would change the resident's menu choices. Staff Member 2 provided menus, for some of the residents, titled, "Today's Menu" which indicated Resident C had cottage cheese requested but it had been crossed out on his menu, Resident M had grilled cheese requested but it had been crossed out and the word "hold back" on the dessert. Staff Member 2 indicated the server was to "hold" the dessert until residents finished the rest of their meal. Resident J's menu had milk written beside each meal, however milk for lunch and dinner had been crossed off. Staff Member 2 indicated the Administrator had instructed the Dietary Staff that residents could only be served milk for breakfast and no juice or milk was to be provided for other meals, even if requested by the resident for the lunch and dinner meals. Resident F's menu had

cottage cheese requested but it had been crossed out.

During an interview, on 1/17/25 at 1:16 P.M., anonymous Staff Member 3 indicated he had observed some incidents in the dining room regarding the Administrator's demeanor with some of the residents. He indicated on one occasion, he had witnessed the Administrator telling Resident P, who usually ate only 1/2 of what was served on her plate, that she bet the resident would not eat everything and the resident had looked distressed by the Administrator's comment. Staff Member 3 indicated Resident F who usually ate everything on his plate and would lick his plate clean had been embarrassed when the Administrator was overheard telling the resident "That was disgusting" referring to the resident licking his plate. He indicated the Administrator had been crossing out menued and requested food items the residents had circled on their menus.

During an interview, on 1/17/25 at 1:42 P.M., the anonymous Staff Member 4 indicated it was the Administrator who had crossed through the food items the residents had chosen for their meals. The Administrator had also instructed staff to "hold" some of the desserts until the resident had eaten all of the

rest of their meals.

2. During an interview, on 1/17/25 at 10:53 A.M., Resident C indicated each day at lunch time, he received a menu for the next day. He circled what he wanted for each meal but the drinks were not included on the menu form. He indicated he circled cottage cheese as he wanted to receive cottage cheese with his lunch and dinner meals. He indicated he had not received the cottage cheese for almost 2 weeks, even though he continued to mark it as requested. He indicated he was not sure why but he thought it had something to do with an incident that had occurred in the dining room a few weeks ago. He indicated when he did not eat everything he had requested, the Administrator told him if he did not eat everything on his plate, she would not "give me anymore food". He indicated this made him feel like a child. He indicated he had requested cottage cheese on the menu everyday since then, but he had not received the cottage cheese. Resident C indicated he had marked cottage cheese as a request on his menu for the lunch and dinner meal on 1/17/2025.

On 1/17/25 from 11:19 AM though 12:01 P.M., the lunch meal was observed being

served. Resident C had not been served cottage cheese and when approached, the server she indicated it had been crossed out on the resident's menu. Observation of Resident C's "Today's Menu" form for the lunch and dinner meal indicated Resident C's cottage cheese request had been crossed out.

On 1/21/25 at 12:40 P.M., a review of the clinical record for Resident C was conducted. The resident's diagnoses included, but were not limited to; cerebral palsy, history of lumbar fracture and spinal cord compression.

A Service Plan, dated 11/4/24, indicated the facility would provide 3 meals, 7 days a week and " ...Resident will have the opportunity to select their meal items ...."

3. During an interview on 1/17/25 at 2:34 P.M., Resident L indicated she could only have one glass of milk a day and only at breakfast per the Administrator. She indicated the Administrator had "put her down" calling her negative, her exact words to her were "You are so negative." Resident L indicated it just was not right and made her feel bad. Resident L indicated she quit asking for milk at her other meals.

On 1/21/25 at 1:04 P.M., a

review of the clinical record for Resident L was conducted. The resident's diagnoses included, but were not limited to; osteoarthritis and age related osteoporosis and history of cerebral infarction due to an embolism. Resident L was alert and oriented.

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she was unsure why this had occurred. She believed the "1/2" meant her sister received smaller portions as she had observed her sister meal had smaller portion than her meal.

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On 1/21/25 at 12:54 P.M., a review of the clinical record for Resident J was conducted. The resident's diagnoses included, but were not limited to; diabetic,

dementia, anxiety, bipolar disorder and vitamin D deficiency. Resident J was alert to self and place, but very heard of hearing.

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wanted as far as he could remember, so he just ate what they gave him.

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During an interview, on 1/21/25

at 2:38 P.M., the Director of Nursing (DON) indicated the Administrator had been reviewing the resident's menus and she was aware the Administrator had been making changes on them by marking out some of the requested items. She indicated she had no idea as to why the Administrator had been doing that but indicated some residents, like Resident L, would mark cottage cheese but then would not eat all of it or any of it, so the Administrator would cross it off. The DON had no idea where the notion of "no milk during lunch or supper" came from because when she first worked at the facility, the residents even had chocolate milk as a choice along with white milk at each meal.

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use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance...Mental Abuse: This includes, but is not limited to, humiliation, harassment, threats of punishment or deprivation...."

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This State Residential finding

	relates to Complaints IN00451001 and IN00449584.			

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided it is determined that other safeguards provide sufficient protection to the patients. (See instructions.)

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