STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	06/02/2026

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 Intake 469737. Intake 469737-State deficiencies related to the allegations are cited at R144 and R214. Survey dates: June 1 and 2, 2026 Facility number: 013327 Residential Census: 23 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-5. Quality review was completed on June 8, 2026.	R 0000		
R 0144	Sanitation and Safety Standards - Deficiency 410 IAC 16.2-5-1.5(a) (a) The facility shall be clean, orderly, and in a state of good	R 0144	1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;	06/23/2026

	repair, both inside and out, and shall provide reasonable comfort for all residents. Based on observation, interview and record review, the facility failed to ensure an environment which was clean, comfortable, and in good repair was provided for 1 of 3 residents reviewed for physical environment. (Resident B) Findings include: In an email, dated 5/17/26 at 9:06 a.m., Resident B's family expressed concerns on the condition of Resident B's apartment when they went to collect his belongings after he passed away. There were concerns with the condition of his bed mattress and feces on the floor and wall.		Resident B is not longer in the facility. Resident B's room was put out of service until all cleaning and repairs are completed and the room is back good working order 2. 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 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; Housekeeping will be in-serviced on room cleaning and notifications on refusals A tracking log will be implanted for daily room cleaning and refusals will be reported to the administrator. 4. How the corrective action(s) will be	

	During an interview, on 6/1/26 at 2:15 p.m., the Administrator in Training indicated Resident B had refused to allow housekeepers into his apartment to clean or vacuum his carpets. The Administrator in Training did not realize the condition of Resident B's room until he passed away. He was unable to locate any interventions placed by the previous Executive Director (ED) related to Resident B's refusals to have his apartment cleaned. During an observation with the Administrator in Training, on 6/1/26 at 2:30 p.m., the following was observed in Resident B's previous apartment: a. The carpet was still present in the apartment, but all Resident B's personal belongings had been removed. The entire carpet throughout the apartment was covered in dark colored stains. Some stains were darker than others. b. There were large dark colored stained areas in the bedroom where the original color of the carpet could not be seen. A cigarette was lying on the bedroom carpet. Cigarette butts were ground in the bedroom carpet. Three green soda pop lids were lying on the		monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; The admin will tour the facility including residents room,with permission, weekly to ensure a safe and clean environment **The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater 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.**	

	bedroom floor. The walls had brown debris smeared halfway up them. A strong urine smell was in the bedroom. The stains on the carpet were worse in the bedroom. c. The original carpet color in the apartment was unable to be distinguished except in the closet where there were no stains on the floor. d. There were approximately greater than 100 used blood glucose testing strips (test strips used with a blood glucose meter) laying on the kitchen floor area. The front of one of the kitchen drawers was off and sitting on the kitchen counter. There were pieces of paper laying on the kitchen carpet. e. A brown colored substance (like feces) was smeared on the carpet in front of the bathroom doorway. The bathroom door was off the hinges. The Administrator in Training indicated the resident had broken the bathroom door for the second time, so it was left off. The bathroom wooden vanity was broken. Both drawers were sitting on the bathroom vanity counter. The toilet lid was sitting on the toilet seat. There was a piece of the bathroom trim off the side of the doorway and leaning against the wall. The bottom of the			

	shower wall was splintered. There was paint peeling off the wall under the hand soap dispenser. f. The front door was splintered from the bottom of the door to a fourth of the way up. The wood inside the door was visible. The Administrator in Training indicated the resident had broken the door before and the door had been replaced; this was the second time he splintered the front door with his electric wheelchair. During a telephone interview, on 6/2/26 at 3:10 p.m., RN 5 (a home health nurse) indicated the first day she went into Resident B's apartment, it smelled like urine. Her shoes would stick to the floor. The floor and bed had feces on it. She started wearing shoe covers on her shoes after the first day she visited. His catheter bag leaked, but he would never let her change it for him. She had informed his nurse about his apartment and educated him on getting his apartment cleaned. The clinical record for Resident B was reviewed on 6/1/26 at 2:29 p.m. The diagnoses included, but were not limited to, chronic pain syndrome, paraplegia, anxiety disorder, pressure ulcer, nicotine dependence, bacterial infection,			

	diabetes mellitus, and a personal history of other infectious and parasitic diseases. Resident B's service plan did not include his refusals or interventions related to his refusals. During an interview, on 6/2/26 at 3:30 p.m., the Interim Executive Director indicated there had recently been some management changes, which did not help the situation with the resident's apartment. The facility should have stepped in and did some interventions with the cleanliness of Resident B's apartment. Resident B should have had interventions listed on his service plan related to what to do when he refused to have his apartment cleaned. The facility did not have a behavior policy and procedure. The facility followed the Indiana Department of Health regulations. This citation relates to Intake 469737.			
R 0214	Evaluation - Deficiency 410 IAC 16.2-5-2(a) (a) An evaluation of the individual needs of each resident shall be initiated prior to admission and shall be updated at least	R 0214	I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident B is no longer in the	06/23/2026

	semiannually and upon a known substantial change in the resident ' s condition, or more often at the resident ' s or facility ' s request. A licensed nurse shall evaluate the nursing needs of the resident. Based on observation, interview, and record review, the facility failed to ensure the individual needs of a resident were evaluated for 1 of 3 residents reviewed for a change in condition. (Resident B) Findings include: In an email, dated 5/17/26 at 9:06 a.m., Resident B's family expressed concerns on the condition of Resident B's apartment when they went to collect his belongings after he passed away. There were concerns with the condition of his bed mattress and feces on the floor and wall. The clinical record for Resident B was reviewed on 6/1/26 at 2:29 p.m. The diagnoses included, but were not limited to, chronic pain syndrome, paraplegia, anxiety disorder, pressure ulcer, nicotine dependence, bacterial infection, diabetes mellitus, and a personal history of other infectious and parasitic diseases. A nursing progress note, dated 11/6/25 at 3:50 p.m., indicated		facility 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. III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; The DON will be in serviced on service plans All service plans will be reviewed to ensure resident needs are being met 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 DON will review the service plan with 5 residents a month to ensure their needs are being meet. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as	

	Resident B refused wound care from the wound nurse. A physician's progress note, dated 2/2/26 at 8:13 p.m., indicated Resident B needed better control of his blood sugar. He did not want any help with his diabetes checks, which was a problem for this resident. A physician's progress note, dated 3/26/26 at 3:57 p.m., indicated Resident B was a difficult resident who did not follow care with the wound on his coccyx area and had developed a new wound at the lower extremities. He initially refused to be examined by the wound physician, but after some persuasion he agreed. A wound care note, dated 4/22/26, indicated Resident B had a chronic non-healing ulceration of the left buttocks which had been present for over seven months and had been worsening. The resident had a suspected infection. He would benefit from hospital admission and possible nursing home placement. The Director of Nursing (DON) was instructed to admit the resident to the hospital. The Nurse Practitioner (NP) advised the resident he needed to be admitted to the hospital and Resident B refused admission to the hospital. The resident reported he was not willing to go to the hospital		indicated.	

because he did not want to be placed in a nursing home.

A physician's progress note, dated 4/30/26 at 3:33 p.m., indicated Resident B had diabetes mellitus which was challenging to control due to his behaviors.

A wound care note, dated 4/30/26, indicated Resident B was seen by his primary care physician but was not sent to the hospital. The resident informed the writer he did not want to get admitted to the hospital because he did not want to get placed in a nursing home.

A wound care note, dated 5/6/26, indicated the facility and agency was informed Resident B would benefit from hospital admission and then being admitted into a facility. A verbal order was given to send the resident to the emergency room, but when written Resident B declined to go to the hospital for evaluation and treatment.

A nursing progress note, dated 5/6/26 at 1:37 p.m., indicated Resident B was started on an antibiotic for an infection related to his pressure ulcer of the left buttocks.

A nursing progress note, dated 5/10/26 at 12:40 p.m., indicated Resident B was found

unresponsive to verbal and tactile stimuli. He was transferred to the hospital.

Resident B's progress notes and wound care notes indicated multiple behaviors related to refusal of care, refusal to have his wound assessed, refusals for wound dressing changes, high glucose levels and refusals of help with his glucometer checks, and refusals of being admitted to the hospital for suspected wound infections on several occasions.

An evaluation of the resident individual needs related to refusals of care was not located.

Resident B's service plan did not include his refusals or interventions related to his refusals.

During an interview, on 6/2/26 at 1:40 p.m., the Director of Nursing (DON) indicated Resident B refused treatment from the wound care company. He was noncompliant with his diabetes, diet, drank Mountain Dew all day, and did his own insulin and blood sugars checks instead of allowing staff to assist him. He gave himself his own showers and baths. He stayed up all night long, then slept during the day. She was unaware his refusals should have been placed on his service plan as a behavior. She did not

realize behaviors were considered a change in condition and needed to have interventions placed so staff knew how to deal with the behaviors. The staff gave shift to shift report, and she believed this was where that kind of information would get passed along.

During a telephone interview, on 6/2/26 at 3:10 p.m., RN 5 (a home health nurse) indicated when she came to the facility to evaluate and treat Resident B's wounds, he would never have a dressing on his wounds. He was noncompliant with keeping his dressings on. He had a catheter bag which leaked, but he would never let her change the catheter. A week prior to his hospitalization, she told Resident B his wounds were getting worse, and he needed to be admitted to the hospital, but he refused to go.

During an interview, on 6/2/26 at 3:30 p.m., the Interim Executive Director indicated the facility did not have a service plan policy and procedure. The facility followed the Indiana Department of Health regulations. The facility should have stepped in and initiated some interventions related to the cleanliness of the resident's apartment. He should have had interventions listed on his service plan.

	This citation relates to Intake 469737.			

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 SIGNATUREJeff Attinger	TITLERVP of Operations	(X6) DATE06/17/2026