

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 09/10/2026	
NAME OF PROVIDER OR SUPPLIER APERION ESTATES PERU, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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 a State Residential Licensure Survey. Survey dates: September 9, 10, 2026. Facility number: 013327 Residential Census: 24 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality Review completed on 9/15/2026	R 0000	<i>This Plan of Correction is the center's credible allegation of compliance.</i> <i>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. The facility respectfully request a desk review.</i>				
R 0117	Personnel - Deficiency 410 IAC 16.2-5-1.4(b) (b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the	R 0117	I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; All residents had the potential to			10/10/2026	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions. Based on interview and record review, the facility failed to ensure one awake staff member, certified in CPR (Cardipulmonary Resuscitation) and first aid was present for four of 42 shifts reviewed for staffing. Findings include: A review of the staffing schedules for the previous 7 days (8/30/2026 - 9/5/2026), provided by the Administrator,	be affected by the alleged deficient practice. 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 the 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 Administrator will maintain a current certification roster. The scheduler will verify that at least one awake staff member with current CPR and first aid certification is on site at all times, including when schedules or assignments change. 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 audit shift coverage daily x2 weeks, weekly x4 weeks, then monthly. Any uncovered shift will be corrected immediately. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6	
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

	was completed on 9/10/26 at 10:15 A.M. and indicated the following: On 8/30/26, there was no CPR/ first aid certified staff member present for second shift. On 9/2/26, there was no CPR/first aid certified staff member present for second shift. On 9/3/26, there was no CPR/first aid certified staff member present for second shift. On 9/5/26, there was no CPR/first aid certified staff member were present for first shift. During an interview, on 9/10/26 at 11:49 A.M., the Administrator confirmed there had been no first aid coverage for the dates listed above. During an interview, on 9/10/26 at 12:28 P.M., the Administrator indicated the facility did not have a policy regarding ensuring there was first aid coverage in the building and the facility followed State rules.		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.	
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

R 0151	Sanitation & Safety Standards -Noncompliance 410 IAC 16.2-5-1.5(h) (h) Any pet housed in a facility shall have periodic veterinary examinations and required immunizations. Based on record review and interview, the facility failed to ensure pets residing within the facility received the required vaccinations for 2 of 4 pets reviewed for vaccinations. Findings include: During a review of animal vaccination records for pets in the facility, on 9/10/2026 at 11:00 A.M. indicated the following: Resident 11's pet's clinical health record from the veterinarian, provided on 9/10/26 at 11:00 A.M. by the Administrator, indicated the pet had had an examination on 2/28/25 and the examination notes indicated the pet was due for another set of vaccinations on 3/21/25. There was no record the pet had received the required vaccinations. The facility pet's clinical health record from the veterinarian, provided by the Administrator on 9/10/26 at 11:00 A.M. indicated the pet had had an examination	R 0151	I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; The Activity Director will obtain current veterinary examination and immunization records for Resident 11's pet and the facility pet and arrange overdue care. 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 pets housed in the facility have the potential to be affected. The Activity Director will review each pet's veterinary and immunization records and address any missing or overdue care. 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 Activity Director will maintain a log of veterinary examinations and immunization due dates and obtain updated records. The Administrator will review responsibility for the log and Pet Policy with the Activity Director. IV. How the corrective action(s) will be monitored to ensure the	10/10/2026
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

	on 9/29/22. The 9/29/22 form indicated the facility's pet had received a rabies vaccine during a past surgery but there was no documentation the pet had received any current vaccinations. During an interview, on 9/10/26 at 11:15 a.m., the Administrator indicated both pets were overdue for their vaccinations. She indicated per the facility's Pet policy, the Activity Director was responsible for ensuring pet vaccinations were up to date. During an interview, on 9/10/26 at 12:20 p.m., the Activity Director indicated she was unaware she was responsible for ensuring pet vaccinations were up to date. A current facility policy, titled "Pet Policy", provided by the Administrator, on 9/10/26 at 11:15 a.m., indicated the following: "1. Pets of residents will have annual veterinarian visits and immunizations. The record of both will be maintained by the Activity Director"		deficient practice will not recur i.e., what quality assurance program will be put into place; The Administrator or designee will audit pet records and the due date log weekly x4 weeks, then monthly. Missing records or overdue care will be addressed. 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.	
R 0273	Food and Nutritional Services - Deficiency 410 IAC 16.2-5-5.1(f) (f) All food preparation and serving areas (excluding areas in residents' units) are maintained in	R 0273	I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; The cook was educated on	10/10/2026

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

	accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation and interview, the facility failed to ensure food was prepared and served in a sanitary manner in 1 of 1 kitchens. The deficient practice had the potential to affect 24 of 24 residents in the facility. Findings include: During a lunch observation, on 9/9/26 at 11:34 A.M., the following was observed: The cook had facial hair that was not covered by a beard net. He wore one glove on his right hand while his left hand remained bare. He touched resident meal tickets with both hands, then reached into a bread container and removed a piece of bread with his right gloved hand. He then placed a glove on his left hand without performing hand hygiene. He continued to touch meal tickets with both gloved hands. He then used both hands to pull up his pants, and without removing his contaminated gloves or washing his hands, he continued meal service and touched the bottom of his shirt and touched numerous meal tickets before touching food plates.		beard coverings, hand hygiene, and changing gloves after contact with meal tickets, clothing, or other nonfood items. 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 receiving meals 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; Dietary staff will be educated on hand hygiene, glove use, and beard coverings. Beard coverings will be available, and staff will change gloves and perform hand hygiene when moving from contaminated items to food handling. 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;	
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

	During an interview, on 9/9/26 at 11:40 A.M., the Cook indicated he should have worn a beard covering before serving food. He indicated he should have washed his hands after touching his clothing and meal cards as they would be considered dirty. During an interview, on 9/9/26 at 11:46 A.M., the Administrator indicated the Cook should have worn a beard net while serving food and should have performed hand hygiene after touching meal tickets and his clothing. A current facility policy, dated 2026, titled "Dress Code" provided by the Administrator, on 9/9/26 at 1:36 P.M., indicated the following: "...7. Beard nets should be used for employees with facial hair...." A current facility policy, dated 2026, titled "Gloves for Food Handling," provided by the Administrator, on 9/9/26 at 1:36 P.M., indicated the following: "...3. Gloves should be discarded when damaged, torn, soiled, or when interruptions occur or when handling something beyond the scope of food prep...."		The Dietary Manager or designee will observe meal preparation or service 5 times a week x2 weeks, weekly x4 weeks, then monthly. Deficient practices will be corrected immediately. 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.	
R 0410	Infection Control - Noncompliance 410 IAC 16.2-5-12(e)(f)(g)	R 0410	I. What corrective action(s) will be accomplished for those residents found to have been	10/10/2026

(e) In addition, a tuberculin skin test shall be completed within three (3) months prior to admission or upon admission and read at forty-eight (48) to seventy-two (72) hours. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered and read.

(f) For residents who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed within one (1) to three (3) weeks after the first test. The frequency of repeat testing will depend on the risk of infection with tuberculosis.

(g) All residents who have a positive reaction to the tuberculin skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis.

Based on record review and interview, the facility failed to accurately document the administration and results of mandatory tuberculin (TB) skin tests performed prior to admission for 1 of 7 residents. (Resident 29)

Findings include:

Review of Resident 29's clinical record was completed on 9/10/26 at 9:50 A.M.. Diagnoses included , but was not limited to,

affected by the deficient practice;

The nurse will review Resident 29's TB records, notify the physician of missing readings and test timing, and follow directions for any testing needed to establish current TB status. Unverifiable readings will not be entered retrospectively.

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. The nurse will review current resident TB records for complete administration and reading documentation and address identified gaps with the physician as appropriate.

III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;

Licensed nurses will be educated on scheduling the second step, reading tests within 48 to 72 hours, and documenting administration and reading dates, results in millimeters of induration, and the staff who administered and read each test. The nurse will track due dates for new

diabetes, hypertension, kidney failure and cognitive impairment.

The first step TB test results, administered on 10/21/25 at 1:30 P.M. only documented the administration of the test and did not include a read date or time. A second step TB test had been administered on 11/18/25 but there was no time administered documented and the second step TB test did not have a read date or time.

During an interview, on 9/10/26 at 11:15 A.M., the Regional Nurse Consultant indicated she was unable to provide information regarding when the TB tests were read with dates and times.

During an interview, on 9/10/26 at 12:28 p.m., the Administrator indicated the facility did not have a policy regarding resident TB testing and followed the state rules.

The Mantoux Tuberculin Skin Testing Fact Sheet from the Centers for Disease Control and Prevention (CDC) website at https://www.cdc.gov/tb/publications/factsheets/testing/Tuberculin_Skin_Testing_Information_for_Health_Care_Providers.pdf accessed on 9/14/26 at 12:01 p.m., guidance included:

"...The skin test reaction should be read between 48 and 72 hours after administration by a

admissions.

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 nurse or designee will audit new admission TB records weekly x4 weeks, then monthly. Missing or incomplete documentation will be addressed promptly.

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

health care worker trained to read TST results. A patient who does not return within 72 hours will need to be rescheduled for another skin test...."			
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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 Jeff Attinger	TITLERVP of Operations	(X6) DATE09/23/2026
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