STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155572	A. BUILDING 00 B. WING	03/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
APERION CARE DEMOTTE	10352 N 600 E COUNTY LINE RD DEMOTTE, IN 46310

(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 Investigation of Complaints IN00426504, IN00428343, and IN00428890. This visit included a COVID-19 Focused Infection Control Survey. Complaint IN00426504 - Federal/State deficiencies related to the allegations are cited at F689. Complaint IN00428343 - Federal/State deficiencies related to the allegations are cited at F689, F695, F883, and F887. Complaint IN00428890 - No deficiencies related to the allegations are cited. Survey dates: March 12 & 13, 2024 Facility number: 000471 Provider number: 155572 AIM number: 100290390 Census Bed Type: SNF/NF: 72 SNF: 5 Residential: 5 Total: 82 Census Payor Type: Medicare: 6 Medicaid: 31 Other: 40 Total: 77 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 3/21/24.	F 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Kelly DeYoung	HFA	04/03/2024

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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
	155572	A. BUILDING 00 B. WING	03/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
APERION CARE DEMOTTE	10352 N 600 E COUNTY LINE RD DEMOTTE, IN 46310

(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 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 observation, record review, and interview, the facility failed to ensure fall prevention interventions were in place, for 1 of 3 residents reviewed for falls. (Resident D) Finding includes: During an observation on 3/12/24 at 12:05 p.m., Resident D was lying in bed. The mattress he was lying on was a regular mattress without bolsters. The wheelchair was positioned next to his bed. There were no anti-tip bars on the wheelchair. During an observation on 3/12/24 at 5:05 p.m., the resident was lying on the bed. There were no anti-tip bars on the wheelchair next to the bed and no bolsters on the mattress. LPN 1 indicated there were no anti-tip bars on the wheelchair and no bolsters on the mattress. Resident D's record was reviewed on 3/12/24 at 4:24 p.m. The diagnoses included, but were not limited to, diabetes mellitus, and stroke. A Significant Change Minimum Data Set assessment, dated 2/20/24, indicated a severely impaired cognitive status, maximum assistance was required for bed mobility and transfers, and	F 0689	This facility requests paper compliance for this citation . 'This Plan of Corrections is the centers credible allegation of compliance. F- 689 1. What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice. Resident D was given a bolster mattress and tippers to his wheelchair. II. How other residents having the potential to be affected by the same practice will be identified and what corrective action(s) will be taken. All residents at risk for falls have the potential to be affected by the alleged deficient practice. A full house audit was completed to ensure all fall interventions are in place per their plan of care.	04/04/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155572	A. BUILDING 00 B. WING	03/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
APERION CARE DEMOTTE	10352 N 600 E COUNTY LINE RD DEMOTTE, IN 46310

(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
	had one fall with a non-major injury. A Care Plan, dated 12/5/23, indicated a risk for falls. An intervention of anti-tip bars to the wheelchair was added on 2/12/24 and a bolster mattress intervention was added 2/26/24. An Initial Fall Note, dated 2/11/24, indicated a fall in the main dining room. The wheelchair went back and the resident fell backwards on his back. He received a small skin tear on the top of his right shoulder. An Interdisciplinary Team Note, dated 2/11/24, indicated the resident would forget at times to unlock his wheelchair. He attempted to push the wheelchair backwards away from the table and it tipped over backward. The intervention of anti-tip bars added to the wheelchair was to be initiated. An Initial Fall Note, dated 2/26/24 at 1:30 a.m., indicated Resident D was found on the floor next to the bed. He was unable to state what happened. There were no injuries. An Interdisciplinary Team Note, dated 2/26/24, indicated Resident D was found on the floor next to his bed, the bed was in the lowest position, and there were no injuries. Hospice was notified and a mattress with bolsters would be placed on the bed. The current Fall Prevention policy, dated 11/21/17 and received from the Administrator, indicated appropriate interventions would be utilized as necessary. All nursing personnel were responsible for ensuring the interventions were utilized and maintained. This citation relates to Complaints IN00426504		III. What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur. DON/Designee to educate nursing staff and the Guardian Angels on all fall interventions in place per their plan of care as well as the fall intervention communication sheet completed for each unit and to be updated by the fall committee after each intervention . IV. How the corrective actions(s) will be monitored to ensure the deficient practice will not recur I.E, what quality measures assurance program will be put into place. Don/Designee will audit 5 resident rooms a week X 4 weeks., 3 resident rooms a week X 4 weeks, 1 resident room a week X 4 weeks, then 1 resident room X 3 months to ensure all fall interventions are in place. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until an average of 90% compliance or greater is achieved X4 consecutive weeks. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. Date of Compliance : 4-4-2024	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155572	A. BUILDING 00 B. WING	03/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
APERION CARE DEMOTTE	10352 N 600 E COUNTY LINE RD DEMOTTE, IN 46310

(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
	and IN00428343. 3.1-45(a)(2)			
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. Based on observation, record review, and interview, the facility failed to ensure oxygen was set at the correct flow rate, for 1 of 1 resident reviewed for oxygen usage. (Resident D) Finding includes: During an observation on 3/12/24 at 12:05 p.m. and 5:05 p.m., Resident D was lying in bed. Oxygen was being administered through a nasal cannula, and the oxygen flow rate was set at 3.5 liters per minute. LPN 1 was interviewed on 3/12/24 at 5:05 p.m., and indicated the oxygen was being administered between 3 and 3.5 liters per minute. She was unsure what the Physician's Order was for the oxygen administration flow rate. Resident D's record was reviewed on 3/12/24 at 4:24 p.m. The diagnoses included, but were not limited to, diabetes mellitus, and stroke.	F 0695	**The facility requests paper compliance for this citation.** This Plan of correction is the centers credible allegation of compliance. F- 695 1 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. Resident D Oxygen was set at the correct liter flow and orders entered to check each shift. 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 receiving oxygen therapy have the potential to be affected by the alleged deficient practice. An audit was completed on all	04/04/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155572	A. BUILDING 00 B. WING	03/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
APERION CARE DEMOTTE	10352 N 600 E COUNTY LINE RD DEMOTTE, IN 46310

(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
	A Significant Change Minimum Data Set assessment, dated 2/20/24, indicated a severely impaired cognitive status, maximum assistance was required for bed mobility and transfers, and oxygen was administered. A Care Plan, dated 12/6/23, indicated oxygen therapy was required. Oxygen was to be administered per the Physician's Orders was an intervention initiated on 12/6/23. A Physician's Order, dated 12/14/23, indicated, "ensure oxygen is set at 2 liters." This citation relates to Complaint IN00428343. 3.1-47(a)(6)		residents with oxygen use to ensure oxygen was set at the ordered liter flow. 3 What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. Don/Designee to educate nursing staff and the Guardian Angela on all residents who use oxygen and ordered liter flow. Oxygen usage list provided to each unit, orders updated to include checking of ordered liter flow each shift, and the Guardian Angels updated rounding sheets with oxygen usage. Oxygen usage list to be updated in clinical with any new oxygen orders and communicated in morning meeting. 4 How the corrective action(s) will be monitored to ensure the deficient practice does not recur. What Quality Assurance program will be put into place. Don/Designee will audit 5 residents oxygen usage a week times 4 weeks, 3 residents oxygen usage a week X 4 weeks, 1 resident oxygen usage a week X 4 weeks, then 1 resident oxygen usage a month X 3 months to ensure oxygen is set at the correct flow rate . The results of these audits will be reviewed in Quality Assurance	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155572	A. BUILDING 00 B. WING	03/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
APERION CARE DEMOTTE	10352 N 600 E COUNTY LINE RD DEMOTTE, IN 46310

(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
			Meeting monthly for 6 months or until and average of 90% compliance or greater is achieved X 4 consecutive weeks. The QA Committee will identify any trends or patterns and maker recommendations to revise the plan of correction as indicated. Date of Compliance : 4-4-2024	
F 0883 SS=E Bldg. 00	483.80(d)(1)(2) Influenza and Pneumococcal Immunizations §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155572	A. BUILDING 00 B. WING	03/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
APERION CARE DEMOTTE	10352 N 600 E COUNTY LINE RD DEMOTTE, IN 46310

(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
	influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.			
	Based on record review and interview, the facility failed to ensure residents received the pneumococcal and influenza immunizations after the resident/Responsible Party had signed a consent for the immunizations, and failed to thoroughly investigate if prior immunizations had been completed, for 3 of 5 residents reviewed for immunizations. (Residents C, D, and J). The facility also administered the influenza and pneumococcal immunizations to a resident who had a declination signed by the Responsible Party	F 0883	**The Facility requests paper compliance for this citation.** This Plan of Correction is the centers credible allegation of compliance. 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	04/04/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155572	A. BUILDING 00 B. WING	03/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
APERION CARE DEMOTTE	10352 N 600 E COUNTY LINE RD DEMOTTE, IN 46310

(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
	for 1 of 5 residents reviewed for immunizations. (Resident E) Findings include: 1. During an interview on 3/12/24 at 11:54 a.m., Resident C indicated he was unable to remember if he had been questioned about his immunizations when he was first admitted to the facility. He indicated if he was due for any of the immunizations, he would like to receive them. Resident C's record was reviewed on 3/12/24 at 2:47 p.m. The diagnoses included, but were not limited to, heart failure. The resident's admission date was 1/29/24. The Admission Minimum Data (MDS) assessment, dated 2/5/24, indicated an intact cognitive status and was offered and declined the influenza and pneumococcal immunizations. The Immunization Record indicated the influenza and the pneumococcal immunizations were refused. The Admission Agreement indicated education on the influenza immunization was completed on 1/30/24 and the resident had already received the influenza immunization and consented for the annual vaccination for influenza. The Admission Agreement indicated education had been completed on the PCV-20 and Prevnar 20 (pneumococcal immunization) and he had received the vaccine in the past. The consent to receive the vaccination was signed on 1/30/24. During an interview, on 3/12/24 at 3:30 p.m., the Director of Nursing (DON) indicated the		deficiencies. The plan of correction is prepared and /or executed solely because it is required by the provisions of federal and state law. F- 883 1 What corrective action action(s) will be accomplished for these those residents found to have been affected by the deficient practice. Resident's C records were obtained from the VA and entered; he is not eligible for flu vax. PCC updated and received the pneumonia vax on 3-28-24. D was offered and refused. Declination signed and uploaded in PCC, & J was offered and refused. Declination signed and uploaded in PCC and resident E is no longer in the facility. 2 How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken. All residents to receive the immunizations have the potential to be affected by the alleged deficient practice. A full house audit was completed to ensure all residents received the immunizations as requested or education if refused. 3 What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155572	A. BUILDING 00 B. WING	03/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
APERION CARE DEMOTTE	10352 N 600 E COUNTY LINE RD DEMOTTE, IN 46310

(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
	Admission Agreement had not indicated when the vaccinations were given. The facility had not attempted to find out when and what immunizations had been administered and when they were previously administered. 2. Resident D's record was reviewed on 3/12/24 at 4:24 p.m. The diagnoses included, but were not limited to, diabetes mellitus and stroke. The resident's admission date was 12/5/23. A Significant Change Minimum Data Set assessment, dated 2/202/4, indicated a severely impaired cognitive status, the influenza immunization had not been received, no reason was indicated, and the pneumococcal immunization was offered and declined. The Immunization Record indicated the influenza and PCV-20/Prevnar immunizations had been refused. The Admission Agreement indicated the education for the influenza and pneumococcal immunization was completed on 12/6/23. The influenza consent indicated he had already received the influenza vaccination and he had refused the influenza vaccine at this time. The pneumococcal immunization indicated he had not already received the immunization and consented for the immunization to be be given. The facility had not administered the pneumococcal immunization. 3. Resident J's record was reviewed on 3/23/24 at 11 a.m. The diagnoses included, but were not limited to, hypertension. The resident's admission dated was 1/8/24.		recur. DON/Designee to educate nursing staff on administering immunizations as per consent, offering education if refused, and documentation for administration or refusals. 4 How the corrective action(s) will be monitored to ensure the deficient practice will not recur. What quality assurance program will be put into place. DON/Designee will audit 5 resident immunizations a week, X 4 weeks, 3 resident immunizations a week X 4 weeks, 1 resident immunization a week times 4 weeks, the n1 resident immunization a month x 3 months to ensure immunizations were provided as requested or education was provided for refusals. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until an average of 90% compliance or greater is achieved X 4 consecutive weeks. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. Date of Compliance: 4-4-2024	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155572	A. BUILDING 00 B. WING	03/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
APERION CARE DEMOTTE	10352 N 600 E COUNTY LINE RD DEMOTTE, IN 46310

(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
	An Admission MDS assessment, dated 1/11/24, indicated an intact cognitive status, the influenza and pneumococcal immunizations were offered and declined. The Immunization Record indicated the influenza and pneumococcal immunizations were refused. The Admission Agreement, dated 1/9/24, indicated it was unknown if the the resident had the influenza immunization and the consent was signed to receive the immunization annually. It was unknown if the pneumococcal immunization had been received and the consent to receive the immunization was signed. Neither of the immunizations had been received. 4. Resident E's record was reviewed on 3/13/24 at 8:25 a.m. The diagnoses included, but were not limited to, stroke and Alzheimer's disease. The resident's admission date was 6/15/23. The Admission Agreement, dated 6/15/23, indicated education was received for the influenza and pneumococcal immunizations and both were signed as declined. A Significant Change MDS assessment, dated 2/14/24, indicated the influenza vaccine had not been received and the pneumococcal immunization was not assessed. The Immunization Record indicated the influenza and pneumococcal immunizations had both been administered on 12/9/23. There were no consents for the immunizations. During an interview, on 3/13/24 at 2 p.m., the Director of Nursing indicated she was unable to			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155572	A. BUILDING 00 B. WING	03/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
APERION CARE DEMOTTE	10352 N 600 E COUNTY LINE RD DEMOTTE, IN 46310

(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
	find signed consents for the immunizations. An Influenza and Pneumococcal Immunization policy, dated 4/21/22, and received from the Administrator as current, indicated the resident or representative would be provided education on the immunizations upon admission and consent would be signed that indicated their choice. They have the opportunity to refuse the immunizations and the refusals would be documented in the clinical record. The medical record was to include at a minimum, if the resident received or did not receive the immunizations. This citation relates to Complaint IN00428343. 3.1-13(a)			
F 0887 SS=D Bldg. 00	483.80(d)(3)(i)-(vii) COVID-19 Immunization §483.80(d) (3) COVID-19 immunizations. The LTC facility must develop and implement policies and procedures to ensure all the following: (i) When COVID-19 vaccine is available to the facility, each resident and staff member is offered the COVID-19 vaccine unless the immunization is medically contraindicated or the resident or staff member has already been immunized; (ii) Before offering COVID-19 vaccine, all staff members are provided with education regarding the benefits and risks and potential side effects associated with the vaccine; (iii) Before offering COVID-19 vaccine, each resident or the resident representative receives education regarding the benefits and risks and potential side effects associated with the COVID-19 vaccine; (iv) In situations where COVID-19 vaccination			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155572	A. BUILDING 00 B. WING	03/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
APERION CARE DEMOTTE	10352 N 600 E COUNTY LINE RD DEMOTTE, IN 46310

(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
	requires multiple doses, the resident, resident representative, or staff member is provided with current information regarding those additional doses, including any changes in the benefits or risks and potential side effects associated with the COVID-19 vaccine, before requesting consent for administration of any additional doses; (v) The resident, resident representative, or staff member has the opportunity to accept or refuse a COVID-19 vaccine, and change their decision; (vi) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident representative was provided education regarding the benefits and potential risks associated with COVID-19 vaccine; and (B) Each dose of COVID-19 vaccine administered to the resident; or (C) If the resident did not receive the COVID-19 vaccine due to medical contraindications or refusal; and (vii) The facility maintains documentation related to staff COVID-19 vaccination that includes at a minimum, the following: (A) That staff were provided education regarding the benefits and potential risks associated with COVID-19 vaccine; (B) Staff were offered the COVID-19 vaccine or information on obtaining COVID-19 vaccine; and (C) The COVID-19 vaccine status of staff and related information as indicated by the Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN). Based on record review and interview, the facility failed to ensure the COVID-19 vaccination and	F 0887	**This facility requests paper compliance for this citation.**	04/04/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155572	A. BUILDING 00 B. WING	03/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
APERION CARE DEMOTTE	10352 N 600 E COUNTY LINE RD DEMOTTE, IN 46310

(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
	boosters were administered to the residents who signed consents to receive them. They also failed to ensure accurate documentation of when and what COVID-19 immunizations had been given prior to admission into the facility, for 2 of 5 residents reviewed for COVID-19 immunizations. (Residents C and J) Findings include: 1. During an interview on 3/12/24 at 11:54 a.m., Resident C indicated he was unable to remember if he had been questioned about his immunizations when he was first admitted to the facility. He indicated if he was due for any of the immunizations he would like to receive them. Resident C's record was reviewed on 3/12/24 at 2:47 p.m. The diagnoses included, but were not limited to, heart failure. The resident's admission date was 1/29/24. The Admission Minimum Data (MDS) assessment, dated 2/5/24, indicated an intact cognitive status. The Immunization Record indicated the COVID-19 booster immunization was refused. The Admission Agreement, dated 1/30/24, indicated he received education, was offered the COVID-19 immunization, and consented to be vaccinated or shown proof of having been vaccinated. There was no documentation the resident had been vaccinated for COVID-19 prior to admission or after admission into the facility. During an interview, on 3/12/24 at 3:30 p.m., the		This Plan of Correction is the centers credible allegation of compliance. 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, **F- 887** 1 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. Resident C records were obtained from the VA and not eligible. PCC updated and J was offered the Covid vaccine and refused. Declination signed and uploaded in PCC. 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 to receive the immunizations have the potential to be affected by the alleged deficient practice. A full house audit was completed to ensure all residents offered Covid Vaccine/Booster and education. 3 What measures will be put into place and what systemic changes will be made to ensure	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155572	A. BUILDING 00 B. WING	03/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
APERION CARE DEMOTTE	10352 N 600 E COUNTY LINE RD DEMOTTE, IN 46310

(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
	Director of Nursing (DON) indicated the Admission Agreement had not indicated when the vaccinations were given. The facility had not attempted to find out when and what immunizations had been administered. 2. Resident J's record was reviewed on 3/23/24 at 11 a.m. The diagnoses included, but not limited to, hypertension. The resident's admission dated was 1/8/24. An Admission MDS assessment, dated 1/11/24, indicated an intact cognitive status. The Immunization Record indicated the COVID-19/Booster vaccination had been refused. The Admission Agreement, dated 1/9/24, indicated a signed consent to be vaccinated or shown proof of having been vaccinated for COVID-19. There was no documentation the resident had been vaccinated for COVID-19 prior to admission or after admission into the facility. This citation relates to Complaint IN00428343.		that the deficient practice does not recur. Don/Designee to educate nursing staff on administering immunizations as per consent, offering education if refused, and documentation for administration or refusals. 4 How the corrective action(s) will be monitored to ensure the deficient practice does not recur. What quality assurance program will be put into place. Don/Designee will audit 5 resident Covid vaccines a week X 4 weeks, 3 resident Covid vaccines a week X 4 weeks, 1 resident Covid vaccines a week X 4 weeks, the n1 resident Covid vaccines a month X 3months to ensure immunizations were provided as requested or education was provided for refusals. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until an average of 90% compliance or greater is achieved x4 consecutive weeks. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. Date of Correction : 4-4-2024	