	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155572	A. BUILDING B. WING	00	COMPLETED 03/13/2024	
		133312			03/13/2024	
NAME OF P	ROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP COD N 600 E COUNTY LINE RD		
APERION	N CARE DEMOTTE	Ξ		TTE, IN 46310		
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	``	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
TAG F 0000	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
0000						
	IN00426504, IN00 visit included a CC Control Survey. Complaint IN0042 related to the allega Complaint IN0042	nvestigation of Complaints 428343, and IN00428890. This DVID-19 Focused Infection 6504 - Federal/State deficiencies ations are cited at F689. 8343 - Federal/State deficiencies ations are cited at F689, F695,	F 0000			
	the allegations are Survey dates: Marc	ch 12 & 13, 2024				
	Facility number: 00					
	Provider number: 1 AIM number: 1002					
	Census Bed Type: SNF/NF: 72 SNF: 5 Residential: 5 Total: 82					
	Census Payor Type	e:				
	Medicare: 6 Medicaid: 31					
	Other: 40					
	Total: 77					
	accordance with 41	reflect State Findings cited in 10 IAC 16.2-3.1.				
			<u> </u>	l	<u> </u>	
Kelly DeYo		OVIDER/SUPPLIER REPRESENTATIVE'S S	GNATURE HFA	TITLE	(X6) DATE 04/03/2024	

Any defiency statement 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.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 3SHN11 Facility ID: 000471

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SU		SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155572	B. W	NG		03/13/	2024
				STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIER		10352 N 600 E COUNTY LINE RD				
APERION	N CARE DEMOTTE			DEMOTTE, IN 46310			
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL	PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		TE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	-	TAG	DEFICIENCY		DATE
F 0689	483.25(d)(1)(2)						
SS=D	Free of Accident						
Bldg. 00	Hazards/Supervisi						
	§483.25(d) Accide						
	The facility must e						
		resident environment					
		accident hazards as is					
	possible; and						
	§483.25(d)(2)Each	n resident receives					
	- ' ' ' '	sion and assistance devices					
	to prevent accider	nts.					
	Based on observation	on, record review, and	F 00	589	This facility requests paper		04/04/2024
	interview, the facilit	ty failed to ensure fall			compliance for this citation .		
	-	tions were in place, for 1 of 3					
	residents reviewed t	for falls. (Resident D)			'This Plan of Corrections is the centers credible allegation of	9	
	Finding includes:				compliance.		
	During an observati	on on 3/12/24 at 12:05 p.m.,			F- 689		
	Resident D was lyin	ng in bed. The mattress he was					
		lar mattress without bolsters.			1. What corrective action (s) w	/ill	
		positioned next to his bed.			be accomplished for those		
	There were no anti-	tip bars on the wheelchair.			residents found to have been		
					affected by the deficient practi		
	-	on on 3/12/24 at 5:05 p.m., the			Resident D was given a bolste	er	
		on the bed. There were no			mattress and tippers to his		
	•	wheelchair next to the bed and			wheelchair.		
		nattress. LPN 1 indicated there s on the wheelchair and no			II I lavo ath an maaidamta la avisan	41	
	bolsters on the matt				II. How other residents having	ıne	
	ooisteis on the matt	1000.			potential to be affected by the same practice will be identified	1	
	Resident D's record	was reviewed on 3/12/24 at			and what corrective action(s)		
		noses included, but were not			be taken. All residents at risk		
		mellitus, and stroke.			falls have the potential to be		
	,	,			affected by the alleged deficie	nt	
	A Significant Chang	ge Minimum Data Set			practice. A full house audit wa		
	assessment, dated 2	/20/24, indicated a severely			completed to ensure all fall		
		status, maximum assistance			interventions are in place per t	their	
	was required for bed	d mobility and transfers, and			plan of care.		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

3SHN11 Facility ID: 000471

If continuation sheet Page 2 of 14

	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	00	COMPLI	
		155572	B. W	ING		03/13/	2024
NAME OF P	PROVIDER OR SUPPLIER		-		ADDRESS, CITY, STATE, ZIP COD		
					N 600 E COUNTY LINE RD		
APERION	N CARE DEMOTTE	: 		DEMOTTE, IN 46310			
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	-	TAG	DEFICIENCY)		DATE
	had one fall with a	non-major injury.					
	A C Dl d-4-d	12/5/22 : 1:4-1:-1- f			III. What measures will be put		
		12/5/23, indicated a risk for on of anti-tip bars to the			place and what systemic char	-	
		led on 2/12/24 and a bolster			will be made to ensure that the		
		on was added 2/26/24.			deficient practice does not rec		
	matticss interventio	ni was added 2/20/24.			DON/Designee to educate null staff and the Guardian Angels	-	
	An Initial Fall Note	, dated 2/11/24, indicated a fall			all fall interventions in place p		
		room. The wheelchair went			their plan of care as well as th		
		nt fell backwards on his back.			intervention communication st		
		skin tear on the top of his			completed for each unit and to		
	right shoulder.				updated by the fall committee		
	8				each intervention .		
	An Interdisciplinary	Team Note, dated 2/11/24,					
	indicated the resident would forget at times to				IV. How the corrective actions	(s)	
		air. He attempted to push the			will be monitored to ensure the	, ,	
	wheelchair backwar	rds away from the table and it			deficient practice will not recur I.E,		
	tipped over backwa	rd. The intervention of anti-tip			what quality measures assurance		
	bars added to the wi	heelchair was to be initiated.			program will be put into place.		
					Don/Designee will audit 5 resi	dent	
	An Initial Fall Note	, dated 2/26/24 at 1:30 a.m.,			rooms a week X 4 weeks., 3		
	indicated Resident l	D was found on the floor next			resident rooms a week X 4 we	eks,	
	to the bed. He was t				1 resident room a week X 4		
	happened. There we	ere no injuries.			weeks, then 1 resident room >	(3	
					months to ensure all fall		
		Team Note, dated 2/26/24,			interventions are in place.		
		D was found on the floor next					
		was in the lowest position, and			The results of these audits wil		
	•	es. Hospice was notified and a			reviewed in Quality Assurance		
		ers would be placed on the			Meeting monthly for 6 months	or	
	bed.				until an average of 90%		
	מונים ויים	. 1. 1. 1.1./01/17			compliance or greater is achie		
		evention policy, dated 11/21/17			X4 consecutive weeks. The C		
		he Administrator, indicated			Committee will identify any tre	nds	
		ntions would be utilized as			or patterns and make		
	necessary. All nursi				recommendations to revise th		
	_	aring the interventions were			plan of correction as indicated		
	utilized and maintai	ilicu.			Date of Compliance : 4.4.202	,	
	This citation relates	to Complaints IN00426504			Date of Compliance : 4-4-202	†	

AND PLAN OF CORRECTION IDENTIFICATION NUMBER A		(X2) MULTIPLE CO A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/13/2024		
	PROVIDER OR SUPPLIER		10352	ADDRESS, CITY, STATE, ZIP COD N 600 E COUNTY LINE RD TTE, IN 46310	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
F 0695 SS=D Bldg. 00	Suctioning § 483.25(i) Respir tracheostomy care The facility must eneeds respiratory tracheostomy care is provided such oprofessional stand comprehensive pethe residents' goad 483.65 of this sub Based on observation interview, the facilities at the correct floreviewed for oxygen. Finding includes: During an observation of the facility of the period of the facility of the facilit	e and tracheal suctioning, are, consistent with lards of practice, the erson-centered care plan, is and preferences, and part. on, record review, and ty failed to ensure oxygen was w rate, for 1 of 1 resident in usage. (Resident D) on on 3/12/24 at 12:05 p.m. dent D was lying in bed. administered through a nasal ygen flow rate was set at 3.5 wed on 3/12/24 at 5:05 p.m., and in was being administered iters per minute. She was visician's Order was for the	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 pract Resident D Oxygen was set a correct liter flow and orders entered to check each shift. 2 How other residents have the potential to be affected by same deficient practice will be identified and what corrective action(s) will be taken. All residents receiving oxygen the have the potential to be affect by the alleged deficient practice. An audit was completed on alleged of the set of the s	etice. at the ving the e erapy ted ce.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

3SHN11 Facility ID: 000471

If continuation sheet

Page 4 of 14

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155572	B. W	ING _		03/13/	2024
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	₹			N 600 E COUNTY LINE RD		
 APFRI∩I	N CARE DEMOTTE	:			TTE, IN 46310		
	· OARE DEMOTIL			DEIVIO		-	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	1	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	1	TAG	DEFICIENCY)		DATE
	1 -	ge Minimum Data Set			residents with oxygen use to		
		/20/24, indicated a severely			ensure oxygen was set at the		
		status, maximum assistance			ordered liter flow.		
		d mobility and transfers, and				.	
	oxygen was admini	stered.			3 What measures will be p	out	
	A Coro Diam datal	12/6/22 indicated avvecage			into place and what systemic		
		12/6/23, indicated oxygen ed. Oxygen was to be			changes will be made to ensu		
		e Physician's Orders was an			that the deficient practice does		
	intervention initiate				recur. Don/Designee to education nursing staff and the Guardian		
	mici vention initiate	A OH 12/0/23.			Angela on all residents who us		
	Δ Physician's Order	r, dated 12/14/23, indicated,			oxygen and ordered liter flow.		
	"ensure oxygen is s				Oxygen usage list provided to		
	chaire oxygen is s	et at 2 mers.			each unit, orders updated to		
	This citation relates	to Complaint IN00428343.			include checking of ordered lit	er	
	Time crution relates	7 to Complaint 11 (00 1203 13)			flow each shift, and the Guard		
	3.1-47(a)(6)				Angels updated rounding shee		
	(-)(-)				with oxygen usage. Oxygen u		
					list to be updated in clinical wi	-	
					any new oxygen orders and		
					communicated in morning		
					meeting.		
					4 How the corrective actio	n(s)	
					will be monitored to ensure the	` '	
					deficient practice does not rec	ur.	
					What Quality Assurance prog	ıram	
					will be put into place.		
					Don/Designee will audit 5		
					residents oxygen usage a wee	ek	
					times 4 weeks, 3 residents		
					oxygen usage a week X 4 wee		
					1 resident oxygen usage a we		
					4 weeks, then 1 resident oxyg	en	
					usage a month X 3 months to		
					ensure oxygen is set at the		
					correct flow rate .		
					The results of these audits wil		
			1		reviewed in Quality Assurance	•	

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

PRINTED: 04/16/2024 FORM APPROVED OMB NO. 0938-039

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155572	B. W	NG		03/13/	2024
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER				N 600 E COUNTY LINE RD		
APERION	N CARE DEMOTTE		DEMOTTE, IN 46310				
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					Meeting monthly for 6 months	or	
					until and average of 90%		
					compliance or greater is achie		
					X 4 consecutive weeks. The 0		
					Committee will identify any tre	nas	
					or patterns and maker	_	
					recommendations to revise the		
					plan of correction as indicated	-	
					Date of Compliance: 4-4-202	4	
F 0883	483.80(d)(1)(2)						
SS=E	. , , , , ,	umococcal Immunizations					
Bldg. 00	§483.80(d) Influen	za and pneumococcal					
	immunizations	·					
	§483.80(d)(1) Influ	uenza. The facility must					
	develop policies a	nd procedures to ensure					
	that-						
	(i) Before offering	the influenza immunization,					
	each resident or th	ne resident's representative					
	receives education	n regarding the benefits and					
	·	cts of the immunization;					
		s offered an influenza					
		ober 1 through March 31					
	annually, unless th						
	•	dicated or the resident has					
		unized during this time					
	period;						
	(iii) The resident o						
		s the opportunity to refuse					
	immunization; and						
	· ·	medical record includes					
	the following:	at indicates, at a minimum,					
	(A) That the reside	ent or resident's					
	, ,	s provided education					
	-	efits and potential side					
		a immunization; and					
		ent either received the					
		ation or did not receive the					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

3SHN11 Facility ID: 000471

If continuation sheet

Page 6 of 14

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155572	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 03/13/2024		
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 10352 N 600 E COUNTY LINE RD DEMOTTE, IN 46310				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE		
	influenza immuniz contraindications	zation due to medical or refusal.					
	facility must devel to ensure that- (i) Before offering immunization, each representative receive the benefits and primmunization; (ii) Each resident immunization, unlimedically contrain already been immunization; and (iv) The resident or representative has immunization; and (iv) The resident's documentation that the following: (A) That the residing representative was regarding the beneffects of pneumococcal immunization receive the pneumococcal immunization resident/Resport consent for the immunitations. (Refacility also adminiting pneumococcal immunizations. (Refacility also adminiting pneumococcal immunizations)	or the resident's as the opportunity to refuse a medical record includes at indicates, at a minimum, and the resident's are provided education and potential side accocal immunization; and the entitle entitl	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 this plan of correction does n constitute admission or agree by the provider of the truth of facts alleged or conclusions s	of ot ement the		
	had a declination si	gned by the Responsible Party		forth in the statement of			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

3SHN11 Facility ID: 000471

If continuation sheet Page 7 of 14

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE		SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUIL	LDING	00	COMPL	ETED
		155572	B. WING	G		03/13/	2024
			<u> </u>	CTDEET A	DDDECC CITY CTATE ZID COD		
NAME OF P	ROVIDER OR SUPPLIER	1			ADDRESS, CITY, STATE, ZIP COD		
ADEDION	LOADE DEMOTTE				N 600 E COUNTY LINE RD		
APERIO	N CARE DEMOTTE	:		DEMO	TE, IN 46310		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PI	REFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	for 1 of 5 residents	reviewed for immunizations.			deficiencies. The plan of		
	(Resident E)				correction is prepared and /or		
					executed solely because it is		
	Findings include:				required by the provisions of		
					federal and state law.		
	1. During an intervi	ew on 3/12/24 at 11:54 a.m.,			F- 883		
	Resident C indicate	d he was unable to remember if			1 What corrective action		
	he had been question	ned about his immunizations			action(s) will be accomplished	for	
	when he was first a	dmitted to the facility. He			these those residents found to		
	indicated if he was	due for any of the			have been affected by the defi	icient	
	immunizations, he	would like to receive them.			practice. Resident's C records	;	
					were obtained from the VA an	d	
	Resident C's record was reviewed on 3/12/24 at				entered; he is not eligible for fl	u	
	2:47 p.m. The diagr	noses included, but were not			vax. PCC updated and receiv	ed	
	limited to, heart fail	lure. The resident's admission			the pneumonia vax on 3-28-24	4. D	
	date was 1/29/24.				was offered and refused.		
					Declination signed and upload	led	
	The Admission Mir	nimum Data (MDS)			in PCC, & J was offered and		
	assessment, dated 2	/5/24, indicated an intact			refused. Declination signed ar	nd	
	cognitive status and	was offered and declined the			uploaded in PCC and resident	Eis	
	influenza and pneur	nococcal immunizations.			no longer in the facility.		
	The Immunization	Record indicated the influenza			2 How other residents hav	ina	
		cal immunizations were			the potential to be affected by the		
	refused.	our minimum automs were			same deficient practice will be		
	reruseu.				identified and what corrective		
	The Admission Ag	reement indicated education			actions(s) will be taken. All		
	_	munization was completed on			residents to receive the		
		dent had already received the			immunizations have the poten	tial	
		ation and consented for the			to be affected by the alleged	uai	
	annual vaccination				deficient practice. A full house		
					audit was completed to ensure		
	The Admission Ag	reement indicated education			residents received the	Juli	
	_	I on the PCV-20 and Prevnar 20			immunizations as requested o	r	
		nunization) and he had received			education if refused.	-	
		ast. The consent to receive the			2233451111314004.		
	vaccination was sig				3 What measures will be p	out	
					in place and what systemic		
	During an interview	y, on 3/12/24 at 3:30 p.m., the			changes will be made to ensur	re	
	-	(DON) indicated the			that the deficient practice does		
		(=)	1		and the denoising produce docs		

STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPLETED	
		155572	B. WI	NG		03/13/2024	
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIER	S.		1	N 600 E COUNTY LINE RD		
APERIO	N CARE DEMOTTE		DEMOTTE, IN 46310				
(X4) ID	CLIMMAADV	STATEMENT OF DEFICIENCIE	1	ID		(X5)	
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG	`	LISC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE	
		ent had not indicated when the			recur. DON/Designee to educ		
	_	iven. The facility had not			nursing staff on administering		
	attempted to find out when and what				immunizations as per consent		
	immunizations had been administered and when				offering education if refused, a		
	they were previously administered.				documentation for administrati		
					or refusals.		
	2. Resident D's record was reviewed on 3/12/24 at						
	4:24 p.m. The diagnoses included, but were not				4 How the corrective action	n(s)	
	limited to, diabetes mellitus and stroke. The				will be monitored to ensure the		
	resident's admission date was 12/5/23.				deficient practice will not recur		
					What quality assurance progra	am	
	A Significant Change Minimum Data Set				will be put into place.		
	assessment, dated 2/202/4, indicated a severely				DON/Designee will audit 5		
	impaired cognitive status, the influenza				resident immunizations a weel	k, X	
		not been received, no reason			4 weeks, 3 resident		
	was indicated, and t	-			immunizations a week X 4 we	eks,	
	immunization was o	offered and declined.			1 resident immunization a wee	ek e	
					times 4 weeks, the n1 residen	t	
		Record indicated the influenza			immunization a month x 3 mor	nths	
		ar immunizations had been			to ensure immunizations were		
	refused.				provided as requested or		
					education was provided for		
	_	reement indicated the			refusals.		
		fluenza and pneumococcal					
		completed on 12/6/23. The			The results of these audits will		
		ndicated he had already			reviewed in Quality Assurance		
		za vaccination and he had			Meeting monthly for 6 months	or	
		a vaccine at this time. The			until an average of 90%	.	
	-	unization indicated he had not			compliance or greater is achie		
	-	e immunization and consented			X 4 consecutive weeks. The 0		
	for the immunizatio	on to be be given.			Committee will identify any tre	nas	
	Th. C: 1' 1 1	and and a finite decreased with a			or patterns and make		
	The facility had not				recommendations to revise the	=	
	pneumococcal imm	unization.			plan of correction as indicated		
	3. Resident I's reco	and was reviewed on 3/23/24 at			Date of Compliance: 4-4-2024		
		ses included, but were not			Date of Compliance, 4-4-2024		
		sion. The resident's admission					
	dated was 1/8/24.	The resident s admission					

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155572	ľ	UILDING	nstruction <u>00</u>	(X3) DATE COMPL 03/13/	ETED
	PROVIDER OR SUPPLIER			10352 N	DDRESS, CITY, STATE, ZIP COD 1 600 E COUNTY LINE RD TE, IN 46310	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
	indicated an intact of	S assessment, dated 1/11/24, cognitive status, the influenza immunizations were offered					
		Record indicated the influenza immunizations were refused.					
	indicated it was unl the influenza immu signed to receive th was unknown if the	reement, dated 1/9/24, known if the the resident had nization and the consent was e immunization annually. It e pneumococcal immunization and the consent to receive the signed.					
	Neither of the imm	unizations had been received.					
	8:25 a.m. The diagr	ord was reviewed on 3/13/24 at moses included, but were not and Alzheimer's disease. The n date was 6/15/23.					
	indicated education	reement, dated 6/15/23, was received for the influenza immunizations and both were					
	1	•					
	and pneumococcal	Record indicated the influenza immunizations had both been /9/23. There were no consents ons.					
		y, on 3/13/24 at 2 p.m., the indicated she was unable to					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

3SHN11 Facility ID: 000471

If continuation sheet Page 10 of 14

	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155572	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		COMI	(X3) DATE SURVEY COMPLETED 03/13/2024	
	ROVIDER OR SUPPLIER		10352	ADDRESS, CITY, STATE, ZIP CO N 600 E COUNTY LINE F TTE, IN 46310			
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LIGO IDENTIFYING DIFFERMATION	ID PREFIX	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETION	
TAG		LSC IDENTIFYING INFORMATION s for the immunizations.	TAG	BEIGERET		DATE	
F 0887 SS=D Bldg. 00	policy, dated 4/21/2 Administrator as curepresentative would the immunizations to would be signed that have the opportunity and the refusals would limited record. The at a minimum, if the receive the immunization relates 3.1-13(a) 483.80(d)(3)(i)-(vii COVID-19 Immunis 483.80(d) (3) COLTC facility must copolicies and proceed following: (i) When COVID-1 facility, each reside is offered the COV immunization is must be en immunized; (ii) Before offering members are proven regarding the beneside effects assoce (iii) Before offering resident or the resident	to Complaint IN00428343.) ization VID-19 immunizations. The develop and implement dures to ensure all the 9 vaccine is available to the ent and staff member VID-19 vaccine unless the edically contraindicated or ff member has already COVID-19 vaccine, all staff rided with education efits and risks and potential iated with the vaccine; I COVID-19 vaccine, each ident representative in regarding the benefits and side effects associated					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

3SHN11 Facility ID: 000471

If continuation sheet Page 11 of 14

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155572	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 03/13/2024	
	PROVIDER OR SUPPLIEF		10352	ADDRESS, CITY, STATE, ZIP COD N 600 E COUNTY LINE RD TTE, IN 46310		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	(X5) COMPLETION	
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
		doses, the resident,				
		tative, or staff member is				
	· ·	ent information regarding				
		oses, including any				
	-	nefits or risks and potential iated with the COVID-19				
		questing consent for				
		any additional doses;				
		esident representative, or				
	• •	the opportunity to accept or				
	refuse a COVID-19 vaccine, and change their decision;					
	(vi) The resident's medical record includes					
	documentation that	at indicates, at a minimum,				
	the following:					
	(A) That the reside	ent or resident				
	representative wa	s provided education				
	regarding the					
	·	ntial risks associated with				
	COVID-19 vaccine					
	` '	COVID-19 vaccine				
	administered to th					
	` '	did not receive the				
	COVID-19 vaccine					
	contraindications					
		aintains documentation				
		OVID-19 vaccination that				
		mum, the following: e provided education				
	, ,	efits and potential risks				
	associated with C					
		ered the COVID-19 vaccine				
	` '	obtaining COVID-19				
	vaccine; and					
		9 vaccine status of staff and				
	, ,	n as indicated by the				
		se Control and Prevention's				
	National Healthca	re Safety Network (NHSN).				
		view and interview, the facility	F 0887	This facility requests paper	04/04/2024	
		COVID-19 vaccination and		compliance for this citation.		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

3SHN11 Facility ID: 000471

If continuation sheet Page 12 of 14

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		00	COMPLETED		
		155572	B. WING			03/13/2024		
		<u> </u>	-	STREET	ADDRESS, CITY, STATE, ZIP COD			
NAME OF PROVIDER OR SUPPLIER					N 600 E COUNTY LINE RD			
APERION CARE DEMOTTE				DEMOTTE, IN 46310				
	1		1		1			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤΕ	COMPLETION	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION						DATE	
	boosters were administered to the residents who				This Plan of Correction is the			
	signed consents to receive them. They also failed				centers credible allegation of			
	to ensure accurate documentation of when and			compliance.				
	what COVID-19 immunizations had been given				Preparation and /or execution of			
	prior to admission into the facility, for 2 of 5			this plan of correction does not				
	residents reviewed for COVID-19 immunizations.			constitute admission or agreement				
	(Residents C and J)			by the provider of the truth of the				
	Findings include:				facts alleged or conclusions s	et		
					forth in the statement of			
					deficiencies. The plan of corre			
	1. During an interview on 3/12/24 at 11:54 a.m.,			is prepared and/or executed solely		olely		
	Resident C indicated he was unable to remember if			because it is required by the				
	he had been questioned about his immunizations				provisions of federal and state	: law,		
	when he was first admitted to the facility. He							
	indicated if he was due for any of the				F- 887			
	immunizations he would like to receive them.				1 What corrective action(s	· .		
					will be accomplished for those	;		
	Resident C's record was reviewed on 3/12/24 at				residents found to have been			
	2:47 p.m. The diagnoses included, but were not			affected by the deficient practice.				
	limited to, heart failure. The resident's admission			Resident C records were obtained				
	date was 1/29/24.			from the VA and not eligible. PCC				
				updated and J was offered the				
	The Admission Minimum Data (MDS)				Covid vaccine and refused.			
	assessment, dated 2/5/24, indicated an intact			Declination signed and uploaded		led		
	cognitive status.				in PCC.			
				2 How other residents		-		
		Record indicated the COVID-19			the potential to be affected by	-		
	booster immunization was refused.			same deficient practice will be		;		
					identified and what corrective			
	The Admission Agreement, dated 1/30/24,				action(s) will be taken. All			
	indicated he received education, was offered the			residents to receive the				
	COVID-19 immunization, and consented to be			immunizations have the potential		itial		
	vaccinated or shown proof of having been			to be affected by the alleged				
	vaccinated.			deficient practice. A full house				
					audit was completed to ensur	e all		
	There was no documentation the resident had			residents offered Covid				
	been vaccinated for COVID-19 prior to admission				Vaccine/Booster and education.			
	or after admission into the facility.				3 What measures will be p	out		
					into place and what systemic			
	During an interview, on 3/12/24 at 3:30 p.m., the				changes will be made to ensu	re		

			I					
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	ONSTRUCTION (X3)	(X3) DATE SURVEY				
AND PLAN	AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING <u>00</u>		COMPLETED			
		155572	B. WING	I	03/13/2024			
			<u> </u>					
NAME OF P	ROVIDER OR SUPPLIEI	R		ADDRESS, CITY, STATE, ZIP COD				
TABLE OF TROVIDER OR BOTTELER			10352 N 600 E COUNTY LINE RD					
APERION	N CARE DEMOTTE		DEMO'	TTE, IN 46310				
77.0 PD	arn a conve			T	77.5			
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)			
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLETION			
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE			
	Director of Nursing (DON) indicated the			that the deficient practice does no	ot			
	Admission Agreement had not indicated when the			recur. Don/Designee to educate				
	vaccinations were given. The facility had not			nursing staff on administering				
	attempted to find or	-		immunizations as per consent,				
	immunizations had			offering education if refused, and				
	miniumzations nad	been administered.		_				
	2 P 11 4 H 1 2/22/24			documentation for administration				
	2. Resident J's record was reviewed on 3/23/24 at			or refusals.				
	11 a.m. The diagnoses included, but not limited to,			4 How the corrective action(s))			
	hypertension. The resident's admission dated was			will be monitored to ensure the				
	1/8/24.			deficient practice does not recur.				
				What quality assurance program				
	An Admission MDS assessment, dated 1/11/24,			will be put into place.				
	indicated an intact cognitive status.			Don/Designee will audit 5 residen	nt			
	marcacca an mace cognitive status.			Covid vaccines a week X 4 weeks				
	The Immunization Record indicated the			3 resident Covid vaccines a week				
	COVID-19/Booster vaccination had been refused.				`			
	COVID-19/Booster vaccination had been refused.			X 4 weeks, 1 resident Covid				
				vaccines a week X 4 weeks, the				
	The Admission Agreement, dated 1/9/24,			n1 resident Covid vaccines a				
	indicated a signed consent to be vaccinated or			month X 3months to ensure				
	shown proof of having been vaccinated for			immunizations were provided as				
	COVID-19.		requested or education was					
				provided for refusals.				
	There was no documentation the resident had		The results of these audits w		.			
	been vaccinated for COVID-19 prior to admission		reviewed in Quality Assurar					
	or after admission into the facility.			Meeting monthly for 6 months or				
	samosten mee uit naturej.			until an average of 90%				
	This citation relates to Complaint IN00428343.			compliance or greater is achieved				
	This citation relates	s to Complaint 11100426343.		_	1			
				x4 consecutive weeks. The QA				
				Committee will identify any trends	5			
				or patterns and make				
				recommendations to revise the				
			plan of correction as indicated.					
				Date of Correction : 4-4-2024				

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 3SHN11 Facility ID: 000471 If continuation sheet Page 14 of 14