PRINTED: 10/16/2024 /ED 039

			THE TED.
CPARTMENT OF HEALTH AND HUN	FORM APPROV		
ENTERS FOR MEDICARE & MEDICA	AID SERVICES		OMB NO. 0938-0
STATEMENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 00	COMPLETED

155039 B. WING 07/24/2024 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 317 BLAIR PIKE WATERS OF PERU SKILLED NURSING FACILITY, THE PERU. IN 46970 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE F 0000 Bldg. 00 This visit was for a Recertification and State F 0000 August 16, 2024 Licensure Survey. Survey dates: July 21, 22, 23, and 24, 2024 **Indiana State Department of** Health Facility number: 000014 Provider number: 155039 Attn: Brenda Buroker, Director AIM number: 100288670 of Long Term Care Census Bed Type: 2 North Meridian Street SNF/NF: 34 Total: 34 Indianapolis, In 46204 Census Payor Type: Medicare: 5 Medicaid: 14 RE: Survey Event ID EU6O11 Other: 15 Total: 34 These deficiencies reflect State Findings cited in Dear Ms. Buroker, accordance with 410 IAC 16.2-3.1. Quality Review completed on 8/5/2024 Please accept the enclosed plan of correction as a credible allegation of compliance to the deficiencies cited during our Recertification and State Licensure Survey conducted on July 24th, 2024 at Water's of Peru. Our latest date of compliance will be August 23, 2024. Hopefully you will find that our

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Administrator 08/16/2024 Debra L Coppernoll

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.

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

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155039	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION C	x3) DATE SURVEY COMPLETED 07/24/2024			
	PROVIDER OR SUPPLIEF	D NURSING FACILITY, THE	STREET ADDRESS, CITY, STATE, ZIP COD 317 BLAIR PIKE PERU, IN 46970					
(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
				remedies are sufficient. Waters of Peru is respectfully requesting paper compliance.				
				If after reviewing our plan of correction, you have question or require further information, please do not hesitate to call me at your convenience at 765-473-4426				
				Sincerely,				
				Debra Coppernoll, HFA Administrator				
F 0625 SS=D Bldg. 00	Based on record rev failed to provide wi the resident and/or	d Policy Before/Upon Trnsfr view and interview, the facility ritten bed hold information to patient representative upon al for 1 of 3 residents reviewed Resident 5).	F 0625	F-625 Notice of Bed hold Police Before/Upon Transfer  It is the policy of this facility to provide the resident or reside	0			

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLETED	
		155039	B. WI	ING		07/24/	/2024
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIEF	8			AIR PIKE		
	OF PERU SKILLE	D NURSING FACILITY, THE	1	PERU,	IN 46970		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	-	TAG			DATE
	Findings include:				representative with a written notice of the duration of the		
	rindings include.				bed hold policy.		
	The record for Resi	dent 5 was reviewed on 7/21/24			bed floid policy.		
		ses included but were not			what corrective action(	s)	
		of central nervous system,			will be accomplished for tho	-	
		iolent behavior, insomnia,			residents found to have been		
		with delusions, anxiety			affected by the deficient		
	disorder, and major	depressive disorder.			practice;		
	A Quarterly MDS (	Minimum Data Set)			Resident #5 was affected by t	his	
		4/17/2024, indicated a BIMS			deficient practice. The bed hol		
		Mental Status) score of 6,			policy was mailed the resident	t	
	severe cognitive im	pairment.			representative on 8/5/2024		
	AD N. 1	. 17/15/2024 . 0.55 D.M					
	-	ated 7/15/2024 at 9:55 P.M.,			h		
		nt was sent to the emergency  for abdominal distention and			how other residents		
		sounds. Nursing staff			having the potential to be affected by the same deficier	nt	
		d hold policy was sent with the			practice will be identified and		
		te technician (EMT) staff.			what corrective action(s) will		
		(2.22)			be taken;	<u>-</u>	
	A Progress Note in	dicated the resident returned			,		
	to facility on 7/20/2	2024. The clinical record did not			All residents who are transferr	ed	
		tion of written notification to			out to the hospital could be		
	the patient represen	tative of the facility bed hold			affected by this deficient pract	ice,	
	policy.				therefore, this plan of correction	on	
					applies to all residents that res	side	
	-	v, on 7/24/2024 at 10:47 A.M.,			in the facility.		
	`	of Nursing) indicated the					
		nailed the bed hold policy to					
		e just notified family or patient			What measures will be		
		hone when the patient is			put into place and what	al a	
		d. She indicated all residents			systemic changes will be ma	iae	
	policy at time of ad	ren a copy of the bed hold			to ensure that the deficient		
	policy at time of ad	1111551OII.			practice does not recur;		
	During an interview	v, on 7/24/2024, at 2:14 P.M.,			The DON/Designee in-service	d	
		that nurses should send the			nursing staff on the "Bed Hold		
		he family by mail or email the			Policy" on 8/21/2024 Addition		

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	ľ		ONSTRUCTION	3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155039	A. BU B. WI	JILDING	00	COMPLETED 07/24/2024	
		133039	B. W1			07/24/2024	
NAME OF I	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD AIR PIKE		
WATERS	S OF PERU SKILLE	ED NURSING FACILITY, THE		· ·	IN 46970		
(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	policy.	R LSC IDENTIFYING INFORMATION		TAG	any staff that fails to comply w	DATE	
		12 P.M., the DON provided a			the points of this in-service will further educated/disciplined as	ll be	
		he Waters Bed Hold Policy", s the policy currently being			indicated.		
		The policy indicated			how the corrective		
		de Resident, Resident's family			action(s) will be monitored to	<b>&gt;</b>	
	member, and/or the	_			ensure the deficient practice	<b>I</b>	
		written form and/or by a tion prior to transfer"			will not recur, i.e., what quali	=	
	terephone conversa	tion prior to transfer			assurance program will be p into place; and	ut	
	2.1.12(-)(25)						
	3.1-12(a)(25) 3.1-12(a)(26)				MDS Coordinator/Design will complete the QA tool titled		
	3.1-12(a)(20)				Notice of Bed Hold Policy		
					(Attachment A). This tool will	be	
					completed daily (M-F) auditing	J	
					residents that go out to the		
					hospital 4 weeks, then weekly	for	
					4 weeks, then monthly for 4 months If the facility is within		
					95% compliance at the end of		
					6 months; then monitoring car		
					stopped. Results of the monitor	oring	
					will be reviewed at the monthly	-	
					QAPI meeting. Any concerns	<b>I</b>	
					have been addressed. Howev any patterns will be identified.	•	
					needed Action Plan will be wri		
					by the QAPI committee. Any		
					written Action Plan will be		
					monitored by the Administrato	r	
					weekly until resolved.		
					by what date the systemic		
					changes for each deficiency		
					will be completed.		
					All systemic changes will be completed by 8/23/2024		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		` ′	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  00			(X3) DATE SURVEY COMPLETED		
		155039	B. W	NG		07/24/	07/24/2024	
	PROVIDER OR SUPPLIER	D NURSING FACILITY, THE		317 BL	ADDRESS, CITY, STATE, ZIP COD AIR PIKE IN 46970			
(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 APPROPRIA DEFICIENCY)	ίΤΕ.	(X5) COMPLETION DATE	
F 0636 SS=D Bldg. 00	483.20(b)(1)(2)(i)( Comprehensive A  Based on record review failed to complete the Assessment in a time residents reviewed fassessments. (Residents reviewed fassessments of the blands assessment for the blands assessment, dated fasses.  An Admission Minial assessment, dated fassessment, dated fassessment, dated fassessment, dated fassessment, and had broken natural teether the MDS assessments (CAA) strengths and preferent and potentially care incontinence, dental (ADL) abilities, and the CAA area for fassessments assessments (CAA) area for fassessments (	seessments & Timing riew and interview, the facility rie resident Care Area rely manner for 1 of 13 ror comprehensive ent 30)  Resident 30 was conducted on A.M. Diagnoses included, but dementia, history of malignant dder, and chronic kidney  mum Data Set (MDS) /2/2024, indicated Resident 30 ret, was frequently incontinent rel, required assistance for transfer and and minimal difficulty with roken or loose-fitting robvious or likely cavity or  nt triggered Care Area (identification of problems, ences) to be further evaluated planned for urinary care, activities of daily living	F 00		F-636 -Comprehensive Assessments and Timing  It is the policy of this facility to complete comprehensive care plans for residents within 14 d  what corrective action( will be accomplished for tho residents found to have been affected by the deficient practice;  Resident #30's comprehensive care plans were completed on 23, 2024 by the MDS Coordin  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;  The MDS Coordinator/Designee complete an audit of all residents Comprehensive/Annual MDS completion of CAA and Care Plans on August 21, 2024.  what measures will be put into place and what systemic changes will be mat to ensure that the deficient practice does not recur;	e lays. lays. ss) se n e n July ator.  nt d I	08/23/2024	

STATEME	ATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MUI		(2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLETED	
		155039	B. W	ING		07/24/2024	
				STREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	_
NAME OF 1	PROVIDER OR SUPPLIE	R			AIR PIKE		
WATER!	S OF PERUSKILLE	ED NURSING FACILITY, THE			IN 46970		
		TO NORTH TO THE	_		1 10070	<u> </u>	
(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		
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE	
		h his strengthening and			The Regional MDS Coordinat		
		icility will continue to assist			in-serviced the MDS Nurse or		
		L's, monitor for changes, and			completion on comprehensive	care	
		n as necessary. The facility			plans related to Care Area		
	_	e planning. ADL abilities will be			Assessment. Additionally,	.::41-	
		re plan to slow or minimize plications, and minimize risks.			any staff that fails to comply v	<b> </b>	
	decime, avoid com	pheations, and minimize risks.			the points of this in-service wi		
	The CAA area for:	urinary incontinence indicated			further educated/disciplined a	S	
		/need. Resident 30 had			indicated.		
	_	ry incontinence related to					
		ed substantial/max assistance			how the corrective		
	_	sident 30 was unable to resist			action(s) will be monitored t		
	_	equiring staff assistance with			ensure the deficient practice		
	_	nging if incontinent episodes			will not recur, i.e., what qual		
	_	ity will continue to assist			assurance program will be p	-	
		DL's, monitor for changes, and			into place; and	,	
		n as necessary. The facility			into piaco, ana		
		e planning. ADL abilities will be			MDS		
	_	re plan to slow or minimize			Coordinator/Designee will		
		plications, and minimize risks.			complete the QA tool Titled		
	,	,			Comprehensive Assessmen	ts	
	The CAA area for	dental care indicated a potential			and Timing (Attachment A).		
		ident 30 triggered due to			tool will be completed weekly		
	_	ite, and noted broken natural			weeks, then monthly times 5		
	teeth. The facility	will monitor Resident 30 for any			months. If the facility is withir	1	
	further issues and o	complaints. The facility will			95% compliance at the end of	<b> </b>	
	continue to monito	r Resident 30 for any problems			6 months; then monitoring ca	n be	
	and notify the phys	sician as needed. Dental care			stopped. Results of the monit	oring	
		n the care plan to slow or			will be reviewed at the month	ly	
	· ·	avoid complications, and			QAPI meeting. Any concerns	will	
	maintain current le	vel of functioning.			have been addressed. howev		
					any patterns will be identified.	Any	
		communication indicated an			needed Action Plan will be wr	itten	
	_	d. Resident 30 triggered due to			by the QAPI committee. Any		
		ng with minimal difficulty, he			written Action Plan will be		
		, and had demonstrated no			monitored by the Administrate	or	
		of his hearing aids. The facility			weekly until resolved.		
		dress any problems, notify the			by what date the systemic		
	physician as neede	d, and proceed to care plan.			changes for each deficiency	'	

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155039	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	X3) DATE SURVEY COMPLETED 07/24/2024	
	PROVIDER OR SUPPLIER	D NURSING FACILITY, THE	STREET ADDRESS, CITY, STATE, ZIP COD 317 BLAIR PIKE PERU, IN 46970			
(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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
	to slow or minimize	Il be addressed in the care plan e decline, avoid complications, at level of functioning.		will be completed.		
	MDS Coordinator in care plan should be the assessment refer comprehensive care.  On 7/24/2024 at 8:4 indicated that Resid facility on 6/28/202 assessment was on days from that date comprehensive care date to be complete comprehensive care by the 21st day of a A policy was provide by the Director of N the Resident Assess dated October 2023 CAA[s] completion days [of the admission of the admissio	e plans should be completed dmission.  ded, on 7/24/2024 at 1:25 P.M., Jursing. The policy was from sment Instrument Manual, . The manual indicated, " The date must be no later than 14 ion date]. The care plan ist be not later than the 7 days		All systemic changes will be complete on 8/23/2024		
F 0656 SS=D	483.21(b)(1)(3) Develop/Impleme	nt Comprehensive Care Plan				
Bldg. 00	failed to ensure a co plan of care was cre behaviors (Resident hospice care (Resid	wiew and interview, the facility omprehensive person centered eated for a resident with (5) and for a resident receiving ent 24) for 2 of 17 residents ehensive care plans.	F 0656	F-656 – Develop/Implement Comprehensive Care Plan  It is the policy of this facility to ensure a comprehensive pers centered plan of care is create	son	

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	IA (X2) MULTIPLE CONSTRUCTION (X3) DA		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLETED	
		155039	B. W	ING		07/24/2024	
		_	-	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIE	R		317 BL	AIR PIKE		
WATERS	S OF PERU SKILLE	ED NURSING FACILITY, THE		PERU,	IN 46970		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	, and the second	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE	
	Findings include:				residents with behaviors and		
	rindings include:				receiving hospice care.		
	1. The record for R	esident 5 was reviewed on			what corrective action	(s)	
		A.M. Diagnoses included but			will be accomplished for the		
		disorder of central nervous			residents found to have bee		
	system, diabetes n	nellitus, violent behavior,			affected by the deficient		
	insomnia, psychoti	c disorder with delusions,			practice;		
	anxiety disorder, an	nd major depressive disorder.					
					The MDS Nurse/Designee		
		t medications included			completed a person-centered		
		osychotic) 0.25 mg (milligram) 1			for resident 5 related to behave	viors	
		bedtime every Sunday for			on August 21, 2024.		
		and Risperidone 0.25 mg give 1			T. MBON. (D. :		
	•	o times a day six days a week			The MDS Nurse/Designee		
	for psychotic disor	der.			completed a hospice care pla	· · · · · · · · · · · · · · · · · · ·	
	A current Care Plan	n, dated 5/7/2024, indicated the			resident 24 on August 21, 202	24.	
		on and physical behaviors			how other residents		
	1	rowing legs over the bed,			having the potential to be		
		neelchair/bed, cursing, hitting,			affected by the same deficie	nt	
		bing staff. Interventions			practice will be identified an		
	included but were	not limited to: administer psych			what corrective action(s) will	I	
	medication as orde	red, monitor medication side			be taken;		
	effects at least dail						
		ord, notify physician as needed,			The MDS Nurse/Designee		
		or medication GDR (Gradual			completed an audit for reside		
		or psychoactive medication			receiving hospice service and	care	
		consultant and psychiatric I services (SS) to visit as			plan completed if needed on		
	needed.	i services (33) to visit as			August 21, 2024.		
	licousu.				The MDS Nurse/Designee		
	Resident 5's clinica	al record lacked a			completed an audit of resider	ıts	
		are Plan for behaviors.			with behaviors and updated the		
					care plan with person centere	· · · · · · · · · · · · · · · · · · ·	
	During an interview	w, on 7/24/2024 at 10:33 A.M.,			interventions on August 21, 2		
	the Social Service	Director indicated the					
		d have been individualized			what measures will be		
	_	nces of each resident. She			put into place and what		
	indicated Resident	5 enjoys watching baseball,			systemic changes will be ma	ade	

EU6O11

	MEDICARE & MEDIC			•	OMB NO. 0938-039	
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED	
		155039	B. WING		07/24/2024	
NAME OF I	PROVIDER OR SUPPLIER	<b>.</b> {		ADDRESS, CITY, STATE, ZIP COD		
				AIR PIKE		
WATERS	S OF PERU SKILLE	D NURSING FACILITY, THE	PERU,	IN 46970		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
	old movies, and IU,	, and indicated the Care Plans		to ensure that the deficient		
	for Resident 5 were	not person-centered.2. A		practice does not recur;		
	record review of Re	esident 24 was completed on				
	7/22/2024 at 8:33 A	A.M. Diagnoses included, but		The DON/Designee in-service t	the	
	were not limited to:	fracture of the humerus,		MDS nurse and Social Services		
	wedge compression	fracture of thoracic vertebra,		person-centered interventions f	or	
	and anxiety disorde			care plans related to behaviors	l l	
				and hospice care plans.		
	A Significant Chan-	ge Minimum Data Set (MDS)		Additionally, any staff that fails	to	
		5/1/2024, indicated Resident 24		comply with the points of this		
	was receiving hospi			in-service will be further educat	red.	
	was receiving nospi	ice services.		and/or disciplined as indicated.		
	A Nurse's Note dat	ted 5/31/2024 at 10:33 A.M.,		and/or disciplined as indicated.		
		ospice company was at the		how the corrective		
		a face-to-face evaluation, and		action(s) will be monitored to		
		et the criteria for hospice		ensure the deficient practice		
	services.			will not recur, i.e., what quality		
				assurance program will be pu	t	
		r, dated 6/3/2024, indicated		into place; and		
		mitted to hospice service on				
		art failure, COPD (chronic		Social Service/Designee	will	
		ary disease), and acute		complete the QA tool titled		
	respiratory failure r	elated to terminal prognosis.		(Attachment A)		
				Develop/Implement		
	A Care Plan could i	not be located in the medical		Comprehensive Care Plan. So	cial	
	record for hospice of	care.		Service will audit 10 random		
				residents a week for 4 weeks,		
	During an interview	v, on 7/24/2024 at 8:36 A.M.,		then 5 random resident weekly	x 4	
	the MDS Coordinat	tor indicated that Resident 24		weeks, then 5 random residents	s a	
	should have a care	plan for hospice care. During		monthly X 5 months related to		
		ne MDS coordinator she		person centered interventions f	or	
	indicated that the re	esident should have a hospice		behaviors and hospice care		
		ded contact information and		plans If the facility is within 95	5%	
	_	e with the hospice company.		compliance at the end of the 6		
				months; then monitoring can be		
	A policy was provide	ded on, 7/24/2024 at 1:25 P.M.,		stopped. Results of the monitor		
		Nursing. The policy titled,		will be reviewed at the monthly	_	
	•	n Assessment/Comprehensive		QAPI meeting. Any concerns w		
		ted, "The Comprehensive		have been addressed. Howeve		
		ner expand on the resident's				
	Care Fian Will lurth	ici expand on the resident's	1	any patterns will be identified. A	any	

AND PLAN OF CORRECTION   IDENTIFICATION NUMBER   155039	STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
NAME OF PROVIDER OR SUPPLIER  WATERS OF PERU SKILLED NURSING FACILITY, THE  (X4) ID SUMMARY STATEMENT OF DEFICIENCIE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL AGE PRESON COMPLETION DEFICIENCY)  TAG REGULATORY OR LSC IDENTIFYING INFORMATION  risks, goals and interventions using the "Person-Centered' Plan of Care approach for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, physical functioning, mental and psychosocial needs"  3.1-35(b)(1)  STREET ADDRESS, CITY, STATE, ZIP COD 317 BLAIR PIKE PERU, IN 46970  (X5)  PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  TAG PROVIDERS PLAN OF CORRECTION (COMPLETION DATE)  OCMPLETION DATE  ID PROVIDERS PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  TAG PROVIDERS PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  TAG PROVIDERS PLAN OF CORRECTION (COMPLETION DATE)  OCMPLETION DATE  OCMPLETION DEFICIENCY  TAG PROVIDERS PLAN OF CORRECTION (COMPLETION DEFICIENCY)  TAG PROVIDERS PLAN OF CORRECTION (COMPLETION DEFICIENCY)  TAG PROVIDERS PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  TAG PROVIDERS PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY  TAG PROVIDERS PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY  TAG PROVIDERS PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY  TAG PROVIDERS PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY  TAG PROVIDERS PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY  TAG PROVIDERS PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY  TAG PROVIDERS PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY  TAG PROVIDERS PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY  TAG PROVIDERS PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY	AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLETED	
WATERS OF PERU SKILLED NURSING FACILITY, THE  (X4) ID SUMMARY STATEMENT OF DEFICIENCIE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Trisks, goals and interventions using the "Person-Centered' Plan of Care approach for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, physical functioning, mental and psychosocial needs"  317 BLAIR PIKE PERU, IN 46970  ID PROVIDERS PLAN OF CORRECTION (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  TAG PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  TAG PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  TAG PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  TAG PROVIDERS PLAN OF CORRECTION (EACH CORRECTION (EACH CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  TAG PROVIDERS PLAN OF CORRECTION (EACH CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  TAG PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  TAG PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  TAG PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  TAG PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  TAG PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  TAG PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  TAG PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  TAG PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE ACTION S			155039	B. W	ING _		07/24	/2024
WATERS OF PERU SKILLED NURSING FACILITY, THE  (X4) ID SUMMARY STATEMENT OF DEFICIENCIE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Trisks, goals and interventions using the "Person-Centered' Plan of Care approach for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, physical functioning, mental and psychosocial needs"  317 BLAIR PIKE PERU, IN 46970  ID PROVIDERS PLAN OF CORRECTION (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  TAG PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  TAG PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  TAG PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  TAG PROVIDERS PLAN OF CORRECTION (EACH CORRECTION (EACH CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  TAG PROVIDERS PLAN OF CORRECTION (EACH CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  TAG PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  TAG PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  TAG PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  TAG PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  TAG PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  TAG PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  TAG PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  TAG PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE ACTION S					STREET A	ADDRESS CITY STATE ZIP COD		
WATERS OF PERU SKILLED NURSING FACILITY, THE  (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION risks, goals and interventions using the "Person-Centered' Plan of Care approach for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, physical functioning, mental and psychosocial needs"  (X5) COMPLETION DATE  ID PREFIX CROSS-REFERENCE TIO THE APPROPRIATE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  Needed Action Plan will be written by the QAPI committee. Any written Action Plan will be monitored by the Administrator weekly until resolved.  Strain Tag PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE  A risks, goals and interventions using the "Person-Centered' Plan of Care approach for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, physical functioning, mental and psychosocial needs"  3.1-35(b)(1) by what date the systemic	NAME OF P	PROVIDER OR SUPPLIER	t .					
(X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  Trisks, goals and interventions using the "Person-Centered' Plan of Care approach for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, physical functioning, mental and psychosocial needs"  (X5) COMPLETION DATE  TAG PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  TAG PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  TAG PROVIDER'S PLAN OF CORRECTION (CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  TAG PROVIDER'S PLAN OF CORRECTION (CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  TAG PROVIDER'S PLAN OF CORRECTION (CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  TAG PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  TAG PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  TAG PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY  TAG PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY  TAG PROVIDER'S	WATERS	S OF PERU SKILLE	D NURSING FACILITY THE					
PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION  risks, goals and interventions using the "Person-Centered' Plan of Care approach for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, physical functioning, mental and psychosocial needs"  3.1-35(b)(1)  PREFIX TAG  PREFI		1			·			1
TAG  REGULATORY OR LSC IDENTIFYING INFORMATION  risks, goals and interventions using the  "Person-Centered' Plan of Care approach for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, physical functioning, mental and psychosocial needs"  3.1-35(b)(1)  REGULATORY OR LSC IDENTIFYING INFORMATION  TAG  Regulatory  TAG  Regulatory  TAG  Regulatory  TAG  Resultative To THE APPROPRIATE  DATE  Resultative Tag  Resultative To THE APPROPRIATE  DATE  Resultative Tag  Resultati						PROVIDER'S PLAN OF CORRECTION		
risks, goals and interventions using the "Person-Centered' Plan of Care approach for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, physical functioning, mental and psychosocial needs"  3.1-35(b)(1)  needed Action Plan will be written by the QAPI committee. Any written Action Plan will be monitored by the Administrator weekly until resolved.  by what date the systemic		`				CROSS-REFERENCED TO THE APPROPRIA	TE	
"Person-Centered' Plan of Care approach for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, physical functioning, mental and psychosocial needs"  3.1-35(b)(1) by what date the systemic	TAG			+	TAG			DATE
resident that includes measurable objectives and timetables to meet the resident's medical, nursing, physical functioning, mental and psychosocial needs"  3.1-35(b)(1)  written Action Plan will be monitored by the Administrator weekly until resolved.  by what date the systemic		1					itten	1
timetables to meet the resident's medical, nursing, physical functioning, mental and psychosocial needs"  3.1-35(b)(1)  monitored by the Administrator weekly until resolved.  by what date the systemic						1 -		
physical functioning, mental and psychosocial needs"  3.1-35(b)(1) weekly until resolved.  by what date the systemic			-					
needs"  3.1-35(b)(1) by what date the systemic						-	or	
3.1-35(b)(1) by what date the systemic			g, mental and psychosocial			weekly until resolved.		
	,	needs						
	,	3.1-35(b)(1)				by what data the averter	mic	
change for each deficiency		3.1-33(0)(1)				changes for each deficiency	шс	1
will be completed.								
will be completed.						Tim be completed.		
8/23/2024						8/23/2024		
						37-37-3-1		
F 0657 483.21(b)(2)(i)-(iii)	F 0657	483.21(b)(2)(i)-(iii)	)					
SS=D Care Plan Timing and Revision	SS=D	Care Plan Timing	and Revision					
Bldg. 00	Bldg. 00							
Based on record review an interview, the facility $F 0657$ F-657 Care Plan timing and $08/23/2024$		Based on record rev	view an interview, the facility	F 0	657	F-657 Care Plan timing and		08/23/2024
failed to revise and updat care plans for activities,  Revision			-			Revision		
residing on the memory care unit, an eye infection,		_						
		_			It is the policy of this facility to			
plans were reviewed (Resident 18) ensure care plans are revised		plans were reviewed	d (Resident 18)			-	d	
and updated for residents.						and updated for residents.		
Finding include:		Finding include:						
The record for Resident 18 was reviewed on what corrective action(s)						•	-	
7/22/2024 at 3:07 P.M. Diagnoses included but will be accomplished for those			_			-		
were not limited to dementia, intellectual residents found to have been							n	
disabilities, Down syndrome, depression and affected by the deficient			-			-		
congestive heart failure. practice;		congestive neart fai	iuic.			practice;		
An Annual MDS (Minimum Data Set)  The MDS Nurse/Designee updated	,	An Annual MDS (A	Jinimum Data Set)			The MDS Nurse/Designed up	dated	
Assessment, dated 5/7/2024, indicated the and revies care plans for resident	,	,						
resident activity preferences were books,  18 on August 21, 2024.	,					· ·	iont.	
magazines, newspapers, listen to music, being						10 011 August 21, 2024.		
around animals.  how other residents	,		pers, interior music, comg			how other residents		
having the potential to be	,	azouna ammun.						
A current Care Plan, dated 1/18/2024 indicated,  affected by the same deficient	,	A current Care Plan	, dated 1/18/2024 indicated.				nt	
ACTIVITIES: Although the resident was practice will be identified and						1		
considered cognitively impaired, is still capable of what corrective action(s) will						1 -		
making decisions about activity involvement and be taken;						1	-	

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

Event ID:

EU6011

Facility ID: 000014

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PRINTED: 10/16/2024

	Γ OF HEALTH AND HU! R MEDICARE & MEDIC						RM APPROVED IB NO. 0938-039
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) N	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER	l í	UILDING	00	COMPLETED	
		155039	B. W		<u></u>	07/24	
				_		****	
NAME OF I	PROVIDER OR SUPPLIEF	1			ADDRESS, CITY, STATE, ZIP COD AIR PIKE		
WATERS	S OF PERU SKILLE	D NURSING FACILITY, THE			IN 46970		
	T	<u> </u>			1		(V.5)
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	<del> </del>	R LSC IDENTIFYING INFORMATION	-	TAG	DEFICIENCE		DATE
		some group activities. She			l		
		g TV, relaxing, coloring &			All the residents that reside in	the	
		h staff & occasionally looking			facility have to potential to be		
		v Resident has times where she			affected by the cited practice,		
		r room or stay in the common			therefore, this plan of correction	on	
		care unit ,color and watch			applied to all residents.		
		ound her. Interventions					
	included, but were	not limited to. She			what measures will be		
	occasionally enjoys	listening to music in the			put into place and what		
	common area of the	Boulevard (locked unit).			systemic changes will be ma	ide	
					to ensure that the deficient		
	A Care Plan, dated	10/21/2021, indicated:			practice does not recur;		
	MEMORY CARE:	The resident resides on the					
	Memory Care unit.	I benefit from the programming			The DON/Designee in-service	<b>!</b>	
		gh it is a locked unit, she is			nursing staff and MDS nurse		
		e unit for special activities I			the policy "Comprehensive Ca		
		nily as desired. Secured Unit.			Plans" on August 21, 2024.		
		ied resident is appropriate for			Additionally, any staff that fails	s to	
		mming. Specialized			comply with the points of this		
	programming provi				in-service will be further education	ated	
	programming provi				and/or disciplined as indicated		
	The resident does n	ot reside on the locked unit			how the corrective	4.	
		e specialized programming.			action(s) will be monitored to	n	
	and does not receive	e specianzea programming.			ensure the deficient practice		
	A current Care Plan	, dated 5/27/2024, indicated the			will not recur, i.e., what qual		
		infection and was non			assurance program will be p	-	
	1	ation and does not understand			into place; and	ut	
	_	The resident gets agitated and			l into piace, allu		
		er room even after multiple			Care Plan/IDT		
		to try to make me understand				tha	
	_	=			Team/Designee will complete		
	why she needed to l	be in isolation.			QA tool titled (Attachment A)		
	Tr. 11 1 1	1			Plan timing and Revision. Ca		
		ny documentation of an eye			Plan/IDT Team/Designee will		
	infection at this tim	e.			of 10 random residents a wee		
					4 weeks, then 5 random resid	ents	

A Care Plan, dated 5/8/2024, indicated the resident

The record lacked any documentation of Resident

had developed an actual pressure injury.

18 having a pressure injury at this time.

weekly x 4 weeks, then 5 random

residents monthly X 5 months for activities, infections, and pressure

ulcers. If the facility is within 95%

compliance at the end of the 6

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155039	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 07/24/2024
	ROVIDER OR SUPPLIER	D NURSING FACILITY, THE	317 BL	ADDRESS, CITY, STATE, ZIP COD AIR PIKE IN 46970	
(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 APPROPRIA DEFICIENCY)	DATE
	of Resident 18's but from pressure injuri During an interview the Director of Nurs were not updated a During an interview the Activity Director	on, on 7/23/2024 at 2:18 P.M., tocks and thighs were free es.  7, on 7/23/2024 at 9:10 A.M., sing indicated the care plans and should have been revised.  7, on 7/23/2024 at 11:44 A.M., or indicated the resident care atted and should have been.		months; then monitoring can be stopped. Results of the monitor will be reviewed at the month QAPI meeting. Any concerns have been addressed. However, any patterns will be identified, needed Action Plan will be wrough the QAPI committee. Any written Action Plan will be monitored by the Administrator weekly until resolved.	oring y will ver, Any itten
	Director provided the Plan Assessment/Coundated, and indicarcurrently used by the indicated."9. The be reviewed and upominimum. The facil plans more often ba	7 P.M., the Social Service ne policy titled, "Baseline Care comprehensive Care Plans", ted the policy was the one ne facility. The policy Comprehensive Care Plans will dated every quarter at a ity may need to review the care sed on changes in the and/or newly developed 1 issues"		by what date the system changes for each deficiency will be completed. 8/23/2024	
F 0679 SS=D Bldg. 00	Based on observation review the facility for program that incorp	on, interview and record ailed to implement an activities orated the resident's interest (3) resident reviewed for (18)	F 0679	F-679 – Activities Meet Interest/Needs Each Resider It is the policy of this facility to implement activity programs to incorporate the residents interested.	hat
	Finding includes:  During an interview	r, on 7/21/2024 at 10:51 A.M.,		and hobbies.  what corrective action( will be accomplished for tho residents found to have been	se

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

Event ID:

EU6O11 Facility ID: 000014

If continuation sheet Page 12 of 30

	IT OF DEFICIENCIES		(V2) MIII TIBLE C	ONETDUCTION	2) DATE CHRVEY
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO		3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED
		155039	B. WING		07/24/2024
NAME OF I	PROVIDER OR SUPPLIEI	R		ADDRESS, CITY, STATE, ZIP COD	
				AIR PIKE	
WATERS	S OF PERU SKILLE	ED NURSING FACILITY, THE	PERU,	IN 46970	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	Resident 18's famil	y indicated the resident used to		affected by the deficient	
	like music and TV.			practice;	
	During an observation, on 7/21/2024 at 1:44 P.M.,			The Activity Director/Designee	
	-	ing in bed with the television		updated the care plan for televisi	ion
		ee it. The television was		preferences for resident 18's on	
	positioned above as	nd at the back of her head.		August 21, 2024.	
	<u> </u>	7/00/0004		The DON/Designee re-arranged	
	_	v, on 7/22/2024 at 10:47		resident 18's room to enable	
		ated it depended on the resident		resident to seen television on	
		not to get out of bed. She		August 21, 2024.	
	indicated we try to	encourage her.			
	During an observation, on 7/22/2024 at 3:03 P.M., Resident 18 remained in bed with the bed sheet			how other residents	
				having the potential to be	
		ied in bed with the bed sheet		affected by the same deficient	
	covering her face.			practice will be identified and	
	The man and four D	idant 10 mag marriages 1		what corrective action(s) will	
		ident 18 was reviewed on		be taken;	
		P.M. Diagnoses included but dementia, intellectual		All the regidents that reside in the	_
		syndrome, depression, and		All the residents that reside in the	F
	congestive heart fai	-		facility have to potential to be	
	congestive heart la	nuic.		affected by the cited practice, therefore, this plan of correction	
	An Annual MDS (N	Minimum Data Set\		applied to all residents.	
		5/7/2024, indicated the		applied to all residerits.	
		ate hearing. The activity		what measures will be	
	-	ocumented as books,		put into place and what	
	*	pers, listen to music, and being		systemic changes will be made	
	around animals.	pers, fisien to music, and being		to ensure that the deficient	<i>'</i>
	around dimilats.			practice does not recur;	
	During an observat	ion, on 7/23/2024 at 8:37 A.M.,		practice does not recui,	
	_	bed with a sheet over her face.		The Administrator/Designee	
				in-services staff on activity	
	A current Care Plan	n, dated 1/18/2024 indicated:		preferences on resident care pla	n
		resident is considered		and ensuring television is visible	
		ed, and still capable of making		resident on August 21, 2024.	
		ivity involvement and prefer to		Additionally, any staff that fails to	,
		oup activities. She would like		comply with the points of this	
	_	to attend activities be		in-service will be further educate	d

honored by staff. She stays busy watching TV,

and/or disciplined as indicted.

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	
		155039	B. W	ING		07/24/	2024
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	8			AIR PIKE		
WATERS	OF PERU SKILLE	D NURSING FACILITY, THE			IN 46970		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	1	& communicating with staff &					
	_	g at magazines. Interventions			how the corrective		
	included, but were not limited to: Through past				action(s) will be monitored to	)	
	history & staff interview it has been determined				ensure the deficient practice	!	
		ewhat important to resident.			will not recur, i.e., what quali	ity	
	Religious programs are on her TV program list.				assurance program will be p	ut	
		n for her. She occasionally			into place; and		
		music in the common area of					
		ough past history and staff			Activity Director/Designe		
		n determined that resident's			will complete the QA tool titled		
	favorite activities are: coloring, counting crayons,				(Attachment A) Activities Mee	t	
	watching some TV and watching what is going on				Interest/Needs Each Resident		
	around her when she is in the common area. A				Activity Director will audit of 10	)	
	pink care has been placed in the resident's room to				random rooms a week for 4		
	assist staff in reside	ent preferences for (TV shows,			weeks, then 5 random rooms	X 4	
	music, of other acti	vities) resident might enjoy			weeks, then 5 random resider	nt	
	while in room.				rooms monthly x 4 months for		
					placement of television and		
	During an observat	ion, on 7/23/2024 at 8:54 A.M.,			activities per residents prefere	ence	
	the residents room	lacked a pink card for			in place. If the facility is within		
	television preference	ces and the television was			95% compliance at the end of	the	
	positioned where th	ne resident could not see it.			6 months; then monitoring car	n be	
					stopped. Results of the monitor	oring	
	During an observat	ion, on 7/23/2024 at 11:23			will be reviewed at the monthly	y	
	A.M., Resident 18	was in bed with coloring book			QAPI meeting. Any concerns	will	
	and crayons in her l	hands. The television was on,			have been addressed. Howev	er,	
	but was placed above	ve her bed to the back of her			any patterns will be identified.	Any	
	head where she cou	lld not see it.			needed Action Plan will be wri	tten	
					by the QAPI committee. Any		
	During an interview	v, on 7/23/2024 at 11:44 A.M.,			written Action Plan will be		
	the Activity Directo	or indicated the resident should			monitored by the Administrato	r	
		V, but her bed was is in the			weekly until resolved.		
	wrong position and	she should have had the pink			by what date the systemic		
	list in her room. She	e indicated the resident did not			changes for each deficiency		
	attend the religious	service on Sunday.			will be completed.		
	On 7/23/2024 at 1:2	27 P.M., the Social Service					
	Director provided the	he policy titled,"Activities			8/23/2024		
	Program", undated,	and indicated the policy was					
	_	sed by the facility. The policy					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155039		A. BU	(X2) MULTIPLE CONSTRUCTION (X A. BUILDING 00 B. WING			X3) DATE SURVEY  COMPLETED  07/24/2024	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 317 BLAIR PIKE PERU, IN 46970				
(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 APPROPRIA DEFICIENCY)	ιΤΕ	(X5) COMPLETION DATE
F 0689 SS=D Bldg. 00	provide an ongoing designed to meet, in comprehensive asserphysical, mental and the residents. 6. Fact are appropriate for interests, culture and 3.1-33(a)  483.25(d)(1)(2) Free of Accident Hazards/Supervisis Based on record revisident reviewed for which resulted in a (Resident 9)  Finding includes:  A record review of 7/23/2024 at 2:03 P were not limited to: muscle weakness.  A Quarterly MDS a indicated Resident 9 was dependent for the tipped over onto the 3-centimeter lacerate amount of blood init when pressure was a were within normal.	ion/Devices liew and interview, the facility se a mechanical lift for 1 of 1 or a facility reported incident, laceration to the scalp.  Resident 9 was completed on M. Diagnoses included, but paraplegia, obesity, and  ssessment, dated 6/11/2024, Was cognitively intact, and	F 06	89	-689 – Free of Accident Hazards/Supervision/Device  It is the policy of this facility to ensure proper use of the mechanical lift by staff.  what corrective action(will be accomplished for tho residents found to have been affected by the deficient practice;  Resident 9 was assessed by the nurse on June 22, 2024 and sto ER to evaluation and treatm 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;  Residents that require the use mechanical lift have the potential in the potential	s) se n the the thenthenent.	08/23/2024

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 07/24/2024 155039 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 317 BLAIR PIKE WATERS OF PERU SKILLED NURSING FACILITY, THE PERU. IN 46970 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE right, and complained of neck and head pain. to be affected by the cited Resident 9 was sent to the emergency room for practice, therefore, this plan of further evaluation. correction applies to resident requiring use of the mechanical lift On 6/22/2024 at 7:10 P.M., Resident 9 arrived back for transfers. from the emergency room with steri-strips covering the sutures to the frontal skull. He what measures will be complained of a minor to moderate headache. put into place and what systemic changes will be made A Care Plan, dated 1/31/2021, and revised on to ensure that the deficient 4/20/2023, indicated Resident 9 was a total assist practice does not recur; for transfers with a mechanical lift. The DON/Designee in-serviced A facility reported incident was sent to the nursing staff on the polit Indiana Department of Health, on 6/23/2024. The "Mechanical Lift Transfers/Usage" report indicated that CNA 12 and CNA 10 were on August 21, 2024. Additionally, transferring resident 9 with a Hoyer lift any staff that fails to comply with (mechanical lift) from his bed to the wheelchair. the points of this in-service will be The Hoyer lift fell over as Resident 9 was being further educated/disciplined as placed in the wheelchair making contact to his indicated. head. Resident 9 was immediately disconnected from the Hoyer lift, and an assessment was how the corrective completed. Resident 9 sustained a 3-centimeter action(s) will be monitored to laceration to the top of his head. Resident 9 was ensure the deficient practice transported to the local hospital. will not recur, i.e., what quality assurance program will be put During an interview, on 7/23/2024 at 1:24 P.M., into place; and CNA 10 indicated that she and CNA 13 were getting Resident 9 up for supper. She indicated Staff Development/Designee CNA 12 was using the Hoyer lift, and she was will complete the QA tool titled assisting. She indicated CNA 12 put the Hoyer lift (Attachment A) Free of Accident legs in between the front wheels and back wheels Hazards/Supervision/Devices. of the wheelchair, and that the legs were not Staff Development will audit of 10 extended or locked. She indicated the Hoyer lift random staff members week for 4 tipped over and hit Resident 9's head. She weeks, then 5 random staff indicated she assisted in pulling the Hoyer lift off members monthly X 4 weeks, and Resident 9's head. then 5 random staff members for 4 months for proper use of the A review of CNA 12 and CNA 10 employee files mechanical lift, this will include

indicated CNA 12 had completed the competency

random shifts. If the facility is

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDIN	NG <u>00</u>	COMPLETED
		155039	B. WING		07/24/2024
NAME OF T	DROLUDED OF CURRY TO		STR	REET ADDRESS, CITY, STATE, ZIP COD	•
NAME OF F	PROVIDER OR SUPPLIER	t .	317	7 BLAIR PIKE	
WATERS	OF PERU SKILLE	D NURSING FACILITY, THE	PE	RU, IN 46970	
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL	PREF	CROSS-REFERENCED TO THE APPROP	
TAG		R LSC IDENTIFYING INFORMATION	TAC		DATE
		e of the Hoyer lift on 10/1/2019,		within 95% compliance at th	
		empleted the competency on		of the 6 months; then monito	-
	4/19/2024.			can be stopped. Results of t	
	1 1 1 1 1 0	1 12		monitoring will be reviewed	at the
		hecklist was provided by the		monthly QAPI meeting. Any	
		that was completed on		concerns will have been	
	3/20/2024-3/21/2024. CNA 12 completed the annual training which included use of the Hoyer lift.  A policy was provided, on 7/24/2024 at 1:25 P.M., by the Director of Nursing. The policy titled, "Guidelines for Mechanical Lift Transfer/Usage", indicated, "About the Mechanical Lift16. Position the lift around the resident's			addressed. However, any pa	
				will be identified. Any neede	
				Action Plan will be written by QAPI committee. Any written	
				Action Plan will be monitore	
				the Administrator weekly un	-
				resolved.	
				resolved.	
				by what date the syst	emic
		Base legs are usually more		changes for each deficient	
		pen positionUsing the		will be completed	
		2. The mechanical lift should		iiii 20 compioses	
		e extended legs slide under		8/23/2024	
		nsfers]. As stated prior, the			
	mechanical lift legs	are able to open and close to			
	accommodate whee	elchair transfers. 33. Slide the			
	legs under the bed u	antil the swivel bar hook of the			
	lift is directly over t	the resident's abdomen. The			
	legs are widened us	ing the shift handle located on			
	_	the legs is essential in order			
		under the mechanical lift. 34.			
		ck so it does not move once			
	the mechanical lift i	is in position"			
	3.1-45(a)(1)				
F 0692	483.25(g)(1)-(3)				
SS=D Bldg. 00	1	n Status Maintenance			
0	2. During an observ	vation, on 7/21/2024 at 1:43	F 0692	F-692 Nutritional/Hydration	n 08/23/2024
	_	vas observed with dry/cracked	1 30,2	Status Maintenance	00,23,2021
		had a coating. The residents			
		ot in reach of the resident.		It is the policy of this facility	to
	_			provide interventions to prev	

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AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. Bl	JILDING	00	COMPLETED	
		155039	B. W	ING		07/24/2024	
				STREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIE	R			AIR PIKE		
WATERS	S OF PERU SKILLE	ED NURSING FACILITY, THE			IN 46970		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE	
	_	ion, on 7/21/2024 at 2:21 P.M.,			significant weight loss and pro	ovide	
	the resident tried to move the bed side table with				adequate fluids.		
	the water pitcher or	n it but was unable to move it.					
					what corrective action(	•	
		ident 18 was reviewed on			will be accomplished for tho		
		P.M. Diagnoses included but			residents found to have been	n	
	were not limited to				affected by the deficient		
		ual disabilities, Down			practice;		
	1	kidney disease stage 3,			T. 501//5		
	dysphagia and congestive heart failure.				The DON/Designee assessed		
	A A LMDC (	W D ( G ()			residents 24 and 18 on Augus	l l	
	An Annual MDS (Minimum Data Set)				2024, interventions to prevent		
	Assessment, dated 5/7/2024, indicated the resident required supervision/touching assistance				weight loss implemented.		
	during for eating.	ipervision/touching assistance			h oth		
	during for eating.				how other residents		
	A aurment agre plan	, dated 8/26/2022, indicated			having the potential to be		
	_	ivities of daily living): the			affected by the same deficie		
		ted assist with eating/drinking,			practice will be identified an what corrective action(s) will		
		xtensive assistance with bed			be taken;	'	
		gnosis of dementia and Down			De taken,		
		ntions included, but were not			All the residents that res	:ide	
	1 -	meals with tray set-up and			in the facility have to potential		
	meals/eating as nee				be affected by the cited practice,		
	l same same				therefore, this plan of correction		
	During an observat	ion, on 7/23/2024 at 8:36 A.M.,			applied to all residents.		
	_	as on the over the bed side					
	table not within rea				what measures will be		
					put into place and what		
	During an observat	ion, on 7/23/2024 at 9:38 A.M.,			systemic changes will be ma	ade	
	Resident 18's water	pitcher was on the over the			to ensure that the deficient		
	bed side table not v	vithin reach of the resident.			practice does not recur;		
	During an observat	ion, on 7/23/2024 at 11:58			The DON/Designee in-service	ed the	
	A.M., Resident 18	was observed in bed, leaning to			dietitian/designee on the "SW.	AT"	
		nch tray on the over the			and "Weight" policy and		
	bedside table. The	resident was trying to hold			implementing interventions to		
		colate liquid. Resident 18 drank			prevent weight loss on Aught	21,	
	1/2 of the chocolate	e liquid and placed it back on			2024. Additionally, any staff		
	the tray. Resident 1	8 was observed with			members that fails to comply	with	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155039		A. B	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 07/24/2024		
	PROVIDER OR SUPPLIER	ED NURSING FACILITY, THE	•	STREET ADDRESS, CITY, STATE, ZIP COD 317 BLAIR PIKE PERU, IN 46970			
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE.	(X5) COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		d a coating on her tongue.  around the residents room to			the points of this in-service will further educated and/or discip		
	assist with her meal	<b>l</b> .			as indicated.		
	Director entered the assist with her lunc	:05 P.M., the Social Service e residents room and started to h meal. The Social Service he chocolate liquid was spilled			how the corrective action(s) will be monitored to ensure the deficient practice		
	on the blanket and i	indicated she would change d try to feed the resident.			will not recur, i.e., what quali assurance program will be p into place; and	ity	
	the Social Service I lips were dry and co	o, on 7/23/2024, at 12:06 P.M., Director indicated the residents' racked and her tongue had a e should have more liquids.			DON/Designee will complete the QA tool titled (Attachment A) Nutritional Assessment Recommendation	ns.	
	provided the policy Documentation", da	40 P.M., the Director of Nursing titled,"Clinical Nutrition ated 4/2017, and indicated the currently used by the facility.			The DON/Designee will audit weights weekly x 6 months for interventions to prevent weigh loss.		
	The policy indicate provided with a suf	d " Residents will be ficient fluid amount and			The DON/Designee will audit 10 random residents		
	status"	ntain proper hydration			receiving weight loss preventi- interventions weekly x 4 week then 5 random residents week	is,	
	3.1-46(a)(1) 3.1-46(b)				4 weeks, then 5 random resid monthly x 4 months for compliance with interventions	ents	
	interview, the facili	on, record review, and ty failed to provide vent significant weight loss reviewed for nutrition, and			the facility is within 95% compliance at the end of the 6 months; then monitoring can be stopped. Populte of the monitoring than the monitoring can be stopped.	ре	
	failed to provide ad	equate fluids for 1 of 2 for hydration. (Residents 24 &			stopped. Results of the monitor will be reviewed at the monthl QAPI meeting. Any concerns have been addressed. Howey	y will	
	Findings include:				any patterns will be identified. needed Action Plan will be wri by the QAPI committee. Any	Any	
	_	vation on 7/21/2024 at 1:42 was observed to appear thin			written Action Plan will be monitored by the Administrato	or	

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ЛLDING	00	COMPL	ETED
		155039	B. W	ING		07/24/	2024
				·			
NAME OF I	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD		
					AIR PIKE		
WATERS	OF PERU SKILLE	D NURSING FACILITY, THE		PERU,	IN 46970		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	BROWING BY AN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	IE	DATE
	and frail.				weekly until resolved.		
					by what date the		
	A record review wa	as completed on 7/22/2024 at			systemic changes for each deficiency will be completed.		
		es included, but were not					
	limited to: fracture of the humerus, wedge				8/23/2024	-	
		re of thoracic vertebra, and			0/10/1011		
	anxiety disorder.						
	A Significant Chan	ge Minimum Data Set (MDS)					
		5/1/2024, indicated Resident					
	24's nutrition was not assessed.						
	24 S nutrition was not assessed.						
	A review of resident 24's weights indicated:						
	- 3/18/24 86.0 (adm	_					
	- 3/30/24 76.8	nosion weight)					
	- 3/31/24 75.5						
	- 4/8/2024 76.1						
	- 5/6/2024 79.6						
	- 6/4/2024 78.1						
	- 0/4/2024 /0.1						
	Physicians' Orders	indicated the following orders:					
	1 -	times a day for Supplement					
	3/21/2024-3/26/202						
	- Regular diet 3/30/						
	1 -	ice 3/30/2024-4/12/2024.					
		times a day for Supplement					
	4/3/2024-5/28/2024						
	- Admit to hospice						
	7 tunnt to nospice	OII 0/ 1/2027.					
	A Nurse's Note dat	ted 3/19/2024 at 2:11 P.M.,					
		24's daughter informed the					
		24 had vomited after she had					
		r indicated that Resident 24					
		stomach with multiple					
	1 -	d, vomiting happened at times					
		d a history of weight loss due					
	· ·						
	to not being able to	keep down.					
	A Mini Nutritional	Assessment, dated 3/20/2024					
	at 8:16 A.M., indica	ated Resident 24 was					

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	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	ľ í		NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		UILDING	00	COMPL	
		155039	B. W	'ING		07/24	/2024
NAME OF D	PROVIDER OR SUPPLIER		•	STREET A	ADDRESS, CITY, STATE, ZIP COD	•	
NAME OF P	ROVIDER OR SUPPLIER			317 BLA	AIR PIKE		
WATERS	OF PERU SKILLE	D NURSING FACILITY, THE		PERU, I	IN 46970		
(X4) ID	SUMMARY	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 APPROPRIA	TE	COMPLETION
TAG	malnourished.	R LSC IDENTIFYING INFORMATION	+	TAG	DEFICIENCY)		DATE
	mamourished.						
	A Nutritional Asses	ssment, dated 3/20/2024 at 8:27					
	A.M., indicated Res	sident 24 was lactose					
	intolerant, drank on	e vanilla Ensure a week, and					
	_	ke even though she reported					
		I. Resident 24 indicated her					
	1 ^ -	er to gain weight to a minimum					
	_	body weight index indicated nt. Interventions recommended					
	_	ear three times a day, and					
	providing lactose-fr						
		ed 3/22/2024 at 12:07 P.M.,					
		e Ensure Clear for 3 days due					
	to awaiting delivery	7.					
	A Nutritional Asses	ssment, dated 4/3/2024 at 7:15					
		2 percent weight loss in					
		eeks. She had been readmitted					
		her hospitalization related to a					
	I -	d tracheal mass. Her body					
		8, indicating she was					
	underweight.						
	An Interdisciplinary	Note, dated 4/17/2024 at 12:53					
		ident 24 was receiving Ensure					
	Clear 237 milliliters	s twice daily, and consumed					
	_	r meals and approximately 50					
	1 ^	lements for 7 days. Continues					
	_	ervices with weight loss					
	_	voidable as disease processes utritional recommendations					
	were placed.	aaraonar recommendations					
	1						
		Note, dated 4/17/2024 at 12:53					
		ident 24 was receiving Ensure					
		s twice daily, and consumed					
	_	r meals and approximately					
	51-75 percent of he	r supplements for 7 days.					

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPL	ETED
		155039	B. WI	NG		07/24/	2024
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER	L			AIR PIKE		
WATERS	OF PERU SKILLE	D NURSING FACILITY, THE			IN 46970		
(X4) ID	SUMMARY	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 APPROPRIA	ΓE	COMPLETION
TAG		LISC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		e hospice services with weight					
	•	unavoidable as disease					
	processes progress. No new nutritional						
	recommendations were placed. Resident 24 was discontinued from nutritional monitoring.						
	discontinued from nutritional monitoring.						
	A Nutritional Asses	sment, dated 4/24/2024 at 8:21					
	A.M., indicated a 11.6 percent weight loss in						
		eks. Resident 24 had good					
		on most days, and does not					
		body mass index was 15.8,					
	•	ight, but closer to her					
	self-reported usual body weight of 78 pounds.						
	Resident 24 to conti	inue with Ensure Clear.					
		ed 5/28/2024 at 3:03 P.M.,					
		ear was discontinued due to					
		d stating the drink makes her					
	sick to her stomach.	•					
	A Care Plan, dated	3/19/2024, and revised on					
		d Resident 24 was at nutritional					
	risk.						
	D	7/24/2024 + 0.22 + 3.5 - 1					
	•	on 7/24/2024 at 9:03 A.M., the					
	, ,	dicated that interventions					
		ut in place when Resident 24					
	was not on hospice	4, and more options to further					
		uld have been put in place.					
	mercase weight sho	uid nave ocen put in piace.					
	A policy was provid	ded on 7/24/2024 at 1:25 P.M.,					
		Jursing. The policy titled,					
	_	d, "Nursing will notify the					
	_	e of any significant weight					
	_	t weight changes is defined as					
		1 month, 7.5% change x 3					
	months, 10% chang	<del>-</del>					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED 155039 B. WING 07/24/2024 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 317 BLAIR PIKE WATERS OF PERU SKILLED NURSING FACILITY, THE PERU. IN 46970 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE F 0695 483.25(i) SS=D Respiratory/Tracheostomy Care and Bldg. 00 Suctioning Based on observation, record review, and F 0695 08/23/2024 F-695 Respirator/Tracheostomy interview, the facility failed to follow physician's Care and Suctioning orders for oxygen use, and store oxygen tubing appropriately for 1 of 2 residents reviewed for It is the policy of this facility to oxygen therapy. (Resident 24) follow physicians orders for oxygen se and to store oxygen Finding includes: tubing appropriately. During an observation on 7/21/2024 at 9:43 A.M. what corrective action(s) and 10:32 A.M., Resident 24 was observed will be accomplished for those sleeping in bed, and her wheelchair was outside residents found to have been the room with the nasal cannula draped over the affected by the deficient wheelchair seat. practice: On 7/21/2024 at 2:40 P.M., Resident 24 was The DON/Designee assessed observed to be connected to the oxygen resident 24 on August 21, 2024 concentrator via nasal cannula. The oxygen and no negative outcome related concentrator was not on, and Resident 24 was to the alleged deficient practice. sleeping, and was pale. On 7/21/2024 at 2:44 P.M., LPN 13 was requested how other residents to check Resident 24's oxygen saturations. having the potential to be Resident 24's oxygen saturation was 84 percent. affected by the same deficient LPN 13 requested Resident 24 to take several deep practice will be identified and breaths, and then noted the oxygen concentrator what corrective action(s) will was not on. The oxygen concentrator was placed be taken: on, and within several minutes Resident 24's oxygen saturations were 93 percent. LPN 13 The DON/Designee completed an stated, "There you go. You are pinking up." audit on August 21, 2024 receiving oxygen for tubing dates and stored During an interview on 7/21/2024 at 2:55 P.M., appropriately and physician CNA 3 indicated Resident 24 was in bed upon her orders. arrival to the shift at 1:00 P.M. what measures will be During an interview on 7/21/2024 at 3:01 P.M., put into place and what LPN 13 indicated she was responsible for the systemic changes will be made

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transition of oxygen. She indicated she was not

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to ensure that the deficient

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155039			(X2) MULTIPLE CO A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/24/2024	
	PROVIDER OR SUPPLIEI S OF PERU SKILLE	ED NURSING FACILITY, THE	317 BL	ADDRESS, CITY, STATE, ZIP COD AIR PIKE IN 46970	
(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)	(X5) COMPLETION DATE
	in an activity due to upright due to prev indicated she was r transitioned from the oxygen concentrate A record review wa 8:33 A.M. Diagnos limited to: chronic	vas in bed, but thought she was a asking the CNA's to keep her ious vomiting. LPN 13 of aware of how resident 24 he portable oxygen tank to the or.  as completed on 7/22/2024 at the included, but were not respiratory failure, COPD to pulmonary disease), and		practice does not recur;  The DON/Designee in-service nursing staff on August 21, 20 on the policy "Guidelines for Transporting and Storage of Oxygen". Additionally, any stathat fails to comply with the poof this in-service will be furthe educated and/or disciplined as indicated.	024 aff oints er
	assessment, dated 6 was cognitively int assessment indicate A Physician's Orde oxygen at 3 liter pe continuously.	ge Minimum Data Set (MDS) 6/1/2024, indicated Resident 24 act, on hospice therapy. The ed oxygen was not in use. r, dated 3/30/2024, indicated r minute per nasal cannula		how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what qual assurance program will be p into place; and  The DON/Designee will comp the QA tool titled (Attachment F-Respiratory/Tracheostomy)	e lity out olete t A)
	indicated a nurse fr Health asked for an 24. LPN 13 was un been placed in bed that Resident 24 ne further notice due t Resident 24 was in observed Resident oxygen saturation v 84 percent with the LPN 13 noted the c LPN 13 turned on t instructed Resident increase her oxygen oxygen saturations	om the State Department of a oxygen saturation of Resident aware that Resident 24 had related to verbalizing to staff eded to remain upright until to vomiting. LPN 13 thought an activity, and had not 24 return to the unit. The was obtained and noted to be nasal cannula in her nares. Oxygen concentrator to be off. The oxygen concentrator, and 24 in breathing exercises to a saturation. Resident 24's recovered to 93 percent on 3		and Suctioning  The DON/Designee will audit residents receiving oxyg times a week x 4 weeks, then times a week x 4 weeks, then once a week x 4 months for p storage of oxygen tubing and following physician orders for oxygen. If the facility is within compliance at the end of the 6 months; then monitoring can be stopped. Results of the month Will be reviewed at the month QAPI meeting. Any concerns have been addressed. However, patterns will be identified.	gen 5 3 proper  95% 6 be oring ly will ver,

pinked up, and was smiling. Resident 24 indicated,

needed Action Plan will be written

	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY  COMPLETED
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155039	A. BUILDING 00 COMPLETED  B. WING 07/24/2024		
			CTDEE	T ADDRESS, CITY, STATE, ZIP COD	0172172021
NAME OF P	PROVIDER OR SUPPLIER			BLAIR PIKE	
WATERS	OF PERU SKILLE	D NURSING FACILITY, THE		J, IN 46970	
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	``	CY MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION DATE
IAG	"I feel better than I		IAG	by the QAPI committee. Any	DATE
	3/25/2024, indicated respiratory disease vexacerbation related respiratory failure.	3/19/2024, and revised on d Resident 24 had chronic with the potential for d to COPD and chronic An intervention, dated d to administer oxygen as		written Action Plan will be monitored by the Administrate weekly until resolved.  by what date the system changes for each deficiency will be completed.	mic
	During an observation the nasal cannula was wheelchair.  During an interview CNA 8 indicated the stored in a respirator A policy was provided by the Director of National Control of Natio	on on 7/23/2024 at 8:34 P.M., as draped over the back of the v, on 7/24/2024 at 8:38 A.M., at nasal cannulas should be ry bag when not in use.  Ided, on 7/24/2024 at 1:25 P.M., Jursing. The policy titled, insporting and Storage of		8/23/2024	
F 0812	been educated on O administration will :"  3.1-47(a)(6)  483.60(i)(1)(2)	"Note: Only staff who have xygen storage and Oxygen manage and administer oxygen			
SS=E Bldg. 00	Based on observation review the facility for ordered snacks were areas observed and thumb the eating surserving in 1 of 2 dirthe potential to affect	e/Prepare/Serve-Sanitary on, interview and record ailed to ensure physician e provided for 1 of 1 pantry failed to ensure staff did not rface of dinner plates when ning rooms observed. This had et all 34 residents who reside tho receive food from the	F 0812	F-812 Food Procurement Store/Prepare/Serve-Sanitary It is the policy of this facility ensure physician ordered snacks are provided to the residents and that staff does not touch the	to

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STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155039	B. W	ING _		07/24/	2024
				STREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF	PROVIDER OR SUPPLIE	₹			AIR PIKE		
WATER	S OF PERLISKILLE	ED NURSING FACILITY, THE			IN 46970		
VV/\ILI\\	- I LINU SINILLE	D NOROHO I AGILITI, THE		i Livo,	114 -10010		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY OI	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					what corrective action(		
	Findings include:				will be accomplished for tho		
	4				residents found to have bee	n	
	1. A food storage area on the south hall was				affected by the deficient		
	observed, on 7/23/2024 at 1:08 P.M. In the refrigerator was a tray with snacks for 6				practice;		
	-	_			The DON/Dee:		
	residents that were dated 7/22/2024, and a hard				The DON/Designee disposed		
	boiled egg in the side door.				the July 22, 2024 snacks and		
	During on interni-	u on 7/22/2024 of 1.14 D.M. 41			boiled eggs in the refrigerator	on	
	During an interview, on 7/23/2024 at 1:14 P.M., the Social Service Director indicated the snacks				the south hall on 7/23/2024	الما	
	should have been passed out last night and the				The DON/Designee assessed		
	hard boiled egg should have been in a container.				residents on August 21, 2024 no negative outcome related to		
	nard boiled egg should have been in a container.				cited deficient practice.	to trie	
	On 7/23/2024 at 2:	12 P.M., the Administrator			cited delicient practice.		
		titled,"Clinical Nutrition			how other residents		
		ated 4/2017, and indicated the			having the potential to be		
		currently used by the facility.			affected by the same deficie	nt	
		d"The Food & Nutrition			practice will be identified an		
		nd snacks to the nursing			what corrective action(s) wil		
	_	eals and at HS. The Food &			be taken;		
	Nutrition departme	nt will maintain a system of			· ·		
	"snack list" for labe	eling and delivering snacks to			All the residents that reside in	the	
	those residents that	receive scheduled snacks as			facility have to potential to be		
		care/preference"2. During a			affected by the cited practice,		
	_	on 7/21/2024 at 11:49 A.M.			therefore, this plan of correction	on	
		., staff was observed removing			applied to all residents		
		vich bag with their bare hands					
		bing dinnerware for 3			what measures will be		
		ing the top of the glassware			put into place and what		
	for 2 residents.				systemic changes will be ma	ade	
	0 7/00/0004	40 4 34 4 4 4 50 135			to ensure that the deficient		
		:40 A.M. through 11:58 A.M.,			practice does not recur;		
		thumbing dinnerware for 6			The DON/Dee:	-1-6	
	residents, and cupping the top of glassware for 2 residents.				The DON/Designee in-service	e statt	
					on the proper handling of	24	
	During on interni-	u on 7/24/2024 at 10.59 A M			dinnerware on August 21, 202		
		v on 7/24/2024 at 10:58 A.M.,			The DO/Designee in-serviced		
		sing indicated that the thumb the edge of the dinnerware,			nursing staff on the administe	ıııg	
	I should not be over	me eage of the amilefware,	1		of physician ordered snacks		

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

PRINTED: 10/16/2024 FORM APPROVED OMB NO. 0938-039

	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155039	(X2) MULTIPLE C A. BUILDING B. WING	onstruction 00	(X3) DATE SUR' COMPLETE 07/24/202	D		
NAME OF PROVIDER OR SUPPLIER WATERS OF PERU SKILLED NURSING FACILITY, THE			STREET ADDRESS, CITY, STATE, ZIP COD 317 BLAIR PIKE PERU, IN 46970					
	S OF PERU SKILLED NURSING FACILITY, THE  SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION  and the glassware should not be cupped.  A policy was provided, on 7/24/2024 at 2:08 P.M., by the Director of Nursing. The policy titled, "Handling Tableware", indicated, "7. All tableware will be handled appropriately so that the eating surface of the utensil/tableware is not contaminated"  3.1-21(2)			PROVIDER'S PLAN OF CORRESCENCE OF CROSS-REFERENCED TO THE APDEFICIENCY)  timely and proper storage items in the refrigerators resident hallways on Au 2024.  how the corrective action shows the corrective action (s) will be monitored ensure the deficient provided into place; and  The DON/Designee will hallway refrigerators 5 times a week x 4 weeks, then 3 week x 4 weeks, then on week x 4 months for prostorage of food items,  The DON/Designee will physician ordered snack	ECOMPLETION DATE  COMPLETION DATE  e of food on the gust 21,  red to actice quality be put  audit the mes a cimes a ace a per			
				resident 5 times a week weeks, then 3 times a week weeks, then once a week months.  The DON/Designee will random meals services weeks, then 5 random near services weeks, then 5 random near services nearly x 4 week random meal services nearly months for proper handle dinnerware by staff.  If the facility is 95% comafter six months the month will stop. Any concerns addressed immediately Quality Assurance and Comprovement action plants.	observe 10 weekly x 4 neals eks, then 5 nonthly x 4 ing of  apliant nitoring will be and have a Quality			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED 155039 B. WING 07/24/2024 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 317 BLAIR PIKE WATERS OF PERU SKILLED NURSING FACILITY, THE PERU. IN 46970 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE completed. The action plan will be reviewed at the monthly QAPI meeting with changes made as appropriate. by what date the systemic changes for each deficiency will be completed. 8/23/2024 F 0880 483.80(a)(1)(2)(4)(e)(f) SS=D Infection Prevention & Control Bldg. 00 F-880 Infection Prevention & Based on observation, interview and record F 0880 08/23/2024 review, the facility failed to ensure staff changes Control gloves and completed hand hygiene when providing peri care for 1 of 1 resident reviewed for It is the policy of this facility to peri care. (Resident 14) ensure staff changes gloves and complete hand hygiene when Finding includes: providing peri care. On 7/22/2024 at 1:25 P.M., CNA 3 and CNA 7 was what corrective action(s) observed providing peri care to Resident 14. CNA will be accomplished for those 3 washed her hands and applied gloves. CNA 7 residents found to have been rolled the resident to the right side and pushed affected by the deficient the brief under the resident. CNA 3 removed the practice; brief from under the resident. CNA 3 used a soapy washcloth and wiped the residents left The DON/Designee assessed groin area, then with the same area of the resident 14 and no negative washcloth, wiped the right groin area. CNA 3 outcome related to the cited moved the residents penis and wiped underneath deficient practice on August 21, it with the same area of the washcloth and then 2014. wiped towards the groin area. CNA 3 then dried the areas with a towel. CNA 7 turned the resident to his left side and CNA 3, with her dirty gloves how other residents applied a clean brief to the resident. CNA 3 having the potential to be removed the bed sheet and covers due to affected by the same deficient wetness. CNA 3 & CNA 7 applied clean linens to practice will be identified and the bed. CNA 3 was observed to move the what corrective action(s) will

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residents pillow, adjust his clothes and move his

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be taken;

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DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 07/24/2024 155039 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 317 BLAIR PIKE WATERS OF PERU SKILLED NURSING FACILITY, THE PERU. IN 46970 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE hands with the dirty gloves still on. All the residents that reside in the During an interview, on 7/22/2024 at 1:57 P.M., facility have to potential to be CNA 3 indicated she did not remove her gloves affected by the cited practice, and wash her hands and should have when she therefore, this plan of correction completes peri care for any resident. applied to all residents. On 7/24/2024 at 1:30 P.M. the Social Service what measures will be Director provided the policy titled, "Guidelines put into place and what For Incontinence Care", undated and indicated systemic changes will be made the policy was the one currently used by the to ensure that the deficient facility. The policy indicated"...5. Apply latex free practice does not recur; non-sterile gloves...12. ...Use separate area of cloth for each stroke... 16. Remove and discard The DON/Designee in-service gloves. 17. Perform hand hygiene. 18. Apply clean nursing staff on hand hygiene and linen or underpad, brief or other incontinent the policy "Guidelines for product(s) as needed...." Incontinence Care" on August 21, 2024. Additionally, any staff that fails to comply with the points of 3.1-18(a) this in-service will be further educated/disciplined as indicated. 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; and The DON/Designee will observe 10 random staff members providing incontinence care for hand hygiene and glove changes weekly x 4 weeks, then 5 random

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the facility is within 95%

staff members weekly x 4 weeks, then 5 random staff members monthly x 4 months, these

observation will include all shifts. If

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

PRINTED: 10/16/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155039	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		X3) DATE SURVEY COMPLETED 07/24/2024			
	PROVIDER OR SUPPLIE	R ED NURSING FACILITY, THE	STREET ADDRESS, CITY, STATE, ZIP COD 317 BLAIR PIKE PERU, IN 46970					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY 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 APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE		
				compliance at the end of the 6 months; then monitoring can be stopped. Results of the monitor will be reviewed at the monthle QAPI meeting. Any concerns have been addressed. However, any patterns will be identified, needed Action Plan will be writely the QAPI committee. Any written Action Plan will be monitored by the Administrator weekly until resolved.	oe oring y will er, Any			
				by what date the system changes for each deficiency will be completed 8/23/2024				

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