STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING COMPLETED			
AND PLAN	OF CORRECTION	155702	B. WING		11/26/2024
NAME OF I	PROVIDER OR SUPPLIE	R		r address, city, state, zip (WEST MATADOR ST	COD
APERIO	N CARE PERU		PERU	, IN 46970	
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION S	
PREFIX TAG	`	NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	PREFIX TAG	CROSS-REFERENCED TO THE DEFICIENCY)	
E 0000					
Bldg	conducted by the In accordance with 42 Survey Date: 11/2 Facility Number: (Provider Number: AIM Number: 200 At this Emergency Care Peru was four Emergency Prepare	003130 155702 0386750 Preparedness survey, Aperion and in compliance with edness Requirements for icaid Participating Providers	E 0000		
	the survey, the cens	certified beds. At the time of sus was 85.			
K 0000					
Bldg. 01	Licensure Survey v Department of Hea 483.90(a). Survey Date: 11/2 Facility Number: (Provider Number: AIM Number: 200 At this Life Safety	003130 155702	K 0000		
LABORATOR	Y DIRECTOR'S OR PRO	VIDER/SUPPLIER REPRESENTATIVE'S S	IGNATURE	TITLE	(X6) DATE

(X6) DATE

Tammy Matthews Administrator 12/18/2024

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: NJNM21 Facility ID: 003130 If continuation sheet Page 1 of 20

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			ľ í	IPLE CONSTRUCTION	î î	TE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER 155702	A. BUILD B. WING	DING <u>01</u>		MPLETED 26/2024
		.00.02		TREET ADDRESS, CITY, STATE, Z.		
NAME OF P	ROVIDER OR SUPPLIEI	R		850 WEST MATADOR ST	ii cob	
APERION	N CARE PERU		F	PERU, IN 46970		
(X4) ID		STATEMENT OF DEFICIENCIE		D PROVIDER'S PLAN OF		(X5)
PREFIX TAG	*	NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		EFIX (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TO DEFICIENCY	THE APPROPRIATE	COMPLETION DATE
IAG	Requirements for P		1.	Ad		DATE
	•	1, 42 CFR 483.90(a), Life Safety				
	from Fire, the 2012	edition of the NFPA (National				
		sociation) 101, LSC (Life Safety				
	Code), and 410 IA0	C 16.2.				
	This one-story facil	lity was determined to be of				
	Type II (222) const	truction and was fully				
	sprinklered. The fa	cility has a fire alarm system				
		on in the corridors, spaces				
	-	rs and hard-wired smoke				
		dent rooms. The facility has a				
capacity of 92 and had a census of 85 at the time of this survey.						
	or this survey.					
		e residents have customary				
	_	lered. All areas providing				
	facility services we	ere sprinklered.				
	Quality Review con	mpleted on 11/27/24				
K 0100	NFPA 101					
SS=E Bldg. 01	General Requiren	nents - Other				
	Based on observation	on and interview, the facility	K 0100) K100 General req	quirements	12/05/2024
		f 1 laundry area dryer rooms		The facility reques		
		other debris. LSC 19.1.1.3.1		compliance for this		
		e facilities shall be designed,		This Plan of Correct		
		nined and operated to minimize fire emergency requiring the		center's credible a	llegation of	
		pants. This deficient practice		compliance. Preparation and or	ovecution	
		y staff as well as staff working		of this plan of corre		
	in the service hall a	-		not constitute adm		
				agreement by the p	provider of	
	Findings include:			the truth of the fac	ts alleged or	
		1 11/06/04 11 00		conclusion set fort		
	Based on observations made on 11/26/24 at 1:32			statement of defici	encies. The	1
l	p.m. during a tour o	of the facility with the tor, the semi-enclosed area		plan of correction i		

PRINTED: 12/18/2024 FORM APPROVED OMB NO. 0938-039

	OF CORRECTION	IDENTIFICATION NUMBER 155702	A. BUILDING B. WING	01	COMPLETED 11/26/2024
	PROVIDER OR SUPPLIER		1850 V	ADDRESS, CITY, STATE, ZIP COD VEST MATADOR ST IN 46970	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	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
	included the two cei mounted therein. Ba observation, the Ma there was a substant the area located beh added that he would soon as possible.	In the divident of the second		provisions of federal and stalaw. 1. Immediate actions taken of those identified who could have been affected: Facility Housekeeping supervisor ensured all areas laundry room were immediately cleaned and from lint. 2. How the facility identified of who could be affected. Housekeeping supervisor did complete walk through of the entire laundry room and service hall to ensure all areas were from lint. 3. measures put into place / system changes: Cleaning schedule initiated of lint cleaning schedule to inclusive surrounding areas. Weekly inspection per lint cleaning schedule check list will be completed to ensure all areas free from lint to include behind dryer. Preventative maintenancheck list will include checking sprinkler heads to ensure the lint free. 4. How the corrective action of monitored: Maintenance Director /design and housekeeping supervisor conduct audits through his preventative maintenance product and her lint cleaning schedule ensure compliance and report results to QAA meeting to enongoing compliance.	s of e ther a ice free n the ide s are d nce g y are will be nee r will ogram e to t

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

Event ID:

NJNM21 Facility ID: 003130

If continuation sheet

Page 3 of 20

PRINTED: 12/18/2024 FORM APPROVED OMB NO. 0938-039

	OF CORRECTION	IDENTIFICATION NUMBER 155702	A. BUILDING B. WING	01	COMPLETED 11/26/2024	
NAME OF PROVIDER OR SUPPLIER APERION CARE PERU		1850 V	ADDRESS, CITY, STATE, ZIP COD VEST MATADOR ST 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 CROSS-REFERENCED TO THE APPRO DEFICIENCY)	BE COMPLI	
K 0200	NFPA 101			="" b=""> b=""> b=""> b=""> b=""> b=""> b=""> =" b=""> =" span=""> bmaintenance director="" designee="" and="" housekeeping="" supervi will="" conduct="" audits through="" his="" preventative="" maintenance="" program her="" lint="" cleaning=" schedule="" to="" ensure compliance="" report="" results="" qaa="" meeting ongoing="" compliance. span=""> span=""> =" bhow=""> span=""> ="" span=""> b=""> ="" b=""> b=""> ="" b=""> span=""> ="" b=""> ="" span=""> ="" span="""> ="" span=""" span="""> ="" span=""" span="""> ="" span=""" span="""	sor="" ="" ="" s=""	
SS=D Bldg. 01	Based on observation failed to ensure 1 or entry lobby area was that required only of 19.2.2.1 states door shall be permitted.	Requirements - Other on and interview, the facility f 1 bathroom door in the main as provided with a door latch one operation to open. LSC as complying with LSC 7.2.1 LSC 7.2.1.5.10.2 requires the an shall open the door leaf with	K 0200	K200 Means of egress requirements - other The facility requests papacompliance for this citation		/2024

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

Event ID:

NJNM21 Facility ID: 003130

If continuation sheet

Page 4 of 20

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			RVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	01	COMPLET	TED
		155702	B. WI	NG		11/26/20	024
	PROVIDER OR SUPPLIE	R	•	1850 W	ADDRESS, CITY, STATE, ZIP COD EST MATADOR ST IN 46970		
(X4) ID	CLIMMADY	CTATEMENT OF DEFICIENCIE	$\overline{}$	ID			(V5)
PREFIX		STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	R LSC IDENTIFYING INFORMATION		TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE '	DATE
TAG		releasing operation. This	+	IAU			DATE
		could staff in the kitchen.					
	deficient practice c	ould staff in the kitchen.			This Plan of Correction is th		
	Findings include:				center's credible allegation of compliance.	-	
	Based on observati	ions made on 11/26/24 at 11:02			P		
	a.m. during a tour	of the facility with the					
	_	etor, the staff restroom door in					
	the main entrance	lobby area was equipped with			Preparation and/or execution	n	
	an independent dea	ad bolt in addition to the			of this plan of correction doe		
	locking punch code	e doorknob. Based on interview			not constitute admission or		
	at the time of obser	rvation, The Maintenance			agreement by the provider of	•	
	Director confirmed	I the staff restroom door had an			the truth of the facts alleged	or	
	1 -	oolt, as well as a punch code			conclusions set forth in the		
	doorknob.				statement of deficiencies. TI		
					plan of correction is prepare	d	
		eviewed with the Administrator			and/or executed solely		
		ce Director the exit conference			because it is required by the		
	on 11/26/24.				provisions of federal and sta	te	
	2.1.10(1)				law.		
	3.1-19(b)						
					1) Immediate actions taken		
					for those people identified:		
					Malutanassasiliss		
					Maintenance director remov	ed	
					the sliding lock mechanism		
					along with the punch code k	-	
					pad and replaced them with a door knob using a key which		
					will be kept at the reception		
					desk and therefore the		
					bathroom door only has on		
					locking mechanism.		
					2) How the facility		
					identified other residents:		
					All other restrooms were		

PRINTED: 12/18/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155702		r í	JILDING NG	onstruction 01	(X3) DATE SURVEY COMPLETED 11/26/2024	
	PROVIDER OR SUPPLIE N CARE PERU	R		1850 W	ADDRESS, CITY, STATE, ZIP COD VEST MATADOR ST IN 46970	
(X4) ID PREFIX TAG	(EACH DEFICIE)	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 APPROPRIA DEFICIENCY) inspected to ensure they me compliance. No other conce were found. 3) Measures put into place System changes: Maintenance director/designee will make	DATE et rns
					monthly checks to ensure the all restrooms require only or releasing operation to open. This will be put on his mont preventative maintenance check list. 4) How the corrective actions will be monitored: Maintenance Director will	ne
					bring results to the QAA meeting for 6 months or unt 100% compliance is achieve x3 consecutive months.	
K 0324 SS=E Bldg. 01	failed to provide an returning cooking a when the kitchen h was designed and i	on and interview, the facility approved method for appliances to where they were sood extinguishing equipment anstalled for 1 of 1 kitchen hood cm. NFPA 96, Standard for	K 0:	324	K324 Cooking facilities This Plan of Correction is the center's credible allegation of compliance. Preparation and or execution this plan of correction des not	of

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

Event ID:

 $NJNM21 \hspace{0.5cm} \textit{Facility ID:} \hspace{0.5cm} 003130$

If continuation sheet

Page 6 of 20

PRINTED: 12/18/2024 FORM APPROVED OMB NO. 0938-039

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	DER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155702	B. W	NG		11/26/	/2024
				CTDEET A	ADDRECC CITY CTATE ZIR COD		
NAME OF I	PROVIDER OR SUPPLIEF	2			ADDRESS, CITY, STATE, ZIP COD EST MATADOR ST		
ADEDIO	A CARE REDIT						
APERION CARE PERU				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 APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	Ventilation Control	and Fire Protection of			constitute admission or agreer	ment	
		ng Operations Section 2011			by the provider of the truth of t		
		1.2.2, states cooking appliances			facts alleged or conclusion set	t	
		shall not be moved, modified,			forth in the statement of		
	_	out prior re-evaluation of the			deficiencies. The plan of corre	ction	
		ystem by the system installer			is prepared and or executed s	olely	
		unless otherwise allowed by			because it is required by the		
		e extinguishing system.			provisions of federal and state	law.	
		ites the fire-extinguishing			Immediate actions taken fo	r	
	l -	quire reevaluation where the			those identified who could hav	e e	
		are moved for the purposes of			been affected:		
		eaning, provided the			Facility maintenance supervise		
	appliances are returned to approved design				along with life safety inspector	•	
	location prior to cooking operations, and any				agreed to current proper		
		xtinguishing system nozzles			placement of the cooking		
		iances are reconnected in			appliance currently under the		
		e manufacturer's listed design			system. Maintenance director		
		.1.2.3.1 states an approved			used paint on the floor to mark	(
		wided that will ensure that the			where the cooking appliance		
		d to an approved design			approved design location s to	be	
		ent practice could affect as			placed.		
	I	ts, 6 staff, and 4 visitors in the			2. How others have the potent		
	kitchen and main di	ining room area.			be affected will be identified a	nd	
					what corrective action will be		
	Findings include:				taken: No other cooking		
					appliances are located in the		
		ons made on 11/26/24 at 1:21			building under a hood system		
		of the facility with the			therefore no others have the		
		tor, the five (5) burner flat grill			potential to be affected.		
		on the cooking line under the			3. Measures put into place /		
		was not provided with an			system changes: Placement		
		nat would ensure that the			markings for cooking applianc		
		ned to an approved design			under the hood system will be		
		been moved for maintenance			added to monthly preventative		
		d on an interview at the time of			maintenance check list to ensu		
		Maintenance Director stated			marking are present and cook	ıng	
		are an approved method			appliance is in the designed		
	_	to ensure that the appliance			location.		
		approved design location after			4. How the corrective actions v	will	
	maintenance or clea	aning and that he would paint			be monitored: Maintenance		

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

Event ID:

NJNM21 Facility ID: 003130

If continuation sheet

Page 7 of 20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155702		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 11/26/2024	
	PROVIDER OR SUPPLIER		1850 V	ADDRESS, CITY, STATE, ZIP COD VEST MATADOR ST IN 46970	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	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)	DATE
K 0351	was returned to it's cleaning. This finding was re	tchen floor to assure the stove designed location after viewed with the Administrator the Director the exit conference		Director/designee will conduct audit through his preventative maintenance program to ensure compliance and report results QAA meetings to ensure ongo compliance. ="" b=""> b=""> b=""> b=""> b=""> b="">	re to
SS=E Bldg. 01	Sprinkler System Based on observation failed to maintain the Installation of State 2010 edition, Section escutcheons, or oth annular space around or shall be listed for deficient practice of the time clock in Findings include: Based on observation Director on 11/26/21:15 p.m., the spring an escutcheon. The exposed the space around interview at the Maintenance Director was missing, and we could	on and interview, the facility the ceiling construction in the ce with NFPA 13, Standard for sprinkler Systems. NFPA 13, on 6.2.7.1 states plates, er devices used to cover the and a sprinkler shall be metallic, or use around a sprinkler. This could affect staff in the vicinity	K 0351	K351 Sprinkler system instillation The facility requests paper compliance for this citation This Plan of Correction is the center's credible allegation of compliance. Preparation and or execution of this plan of correction des not constitute admission or agreement by the provider of the truth of the facts alleged conclusion set forth in the statement of deficiencies. The plan of correction is prepared and or executed solely because it is required by the provisions of federal and statlaw. 1. Immediate action taken Maintenance Director ensure escutcheon was immediately put back on the sprinkler in the clock room. 2. How the facility identified other residents who could be	of n f or ne d te

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155702	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	COM	ie survey ipleted 26/2024
	PROVIDER OR SUPPLIE N CARE PERU	R	1850 V	ADDRESS, CITY, STATE, Z VEST MATADOR ST IN 46970	IP COD	
(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 (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO T DEFICIENCY	ON SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
140	3.1-19(b)	LECTIFICATION THOUSAND THOU		affected. Maintenance direct complete audit of a throughout the face ensure all escutche present and approp placed with no conto 3. Measures put into system changes: No inspections per pre maintenance check completed to ensure escutcheons are pre appropriately placed 4. How the corrective will be monitored: Maintenance Direct designee will conduct through his prevent maintenance progremsure compliance results to QAA meet ensure ongoing conto =""" b="""> ="" b="""> ="" b="""> ="" span="""> ="" b="""> ="" b=""> ="" b=""">	tor did a all sprinkler's ility to eons were priately acerns found. to place / Monthly eventative k list will be re all resent and ed. ive action tor / luct an audit atative ram to e an report etings to empliance.	
i	I		1	1		1

	OF DEFICIENCIES CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155702	(X2) MULTIPLE C A. BUILDING B. WING	construction 01	(X3) DATE SURVEY COMPLETED 11/26/2024
	OVIDER OR SUPPLIER		1850 V	ADDRESS, CITY, STATE, ZIP COD WEST MATADOR ST , IN 46970	
(X4) ID PREFIX TAG	(EACH DEFICIENC	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B: CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	E COMPLETION
1	NFPA 101 Sprinkler System -	Maintenance and Testing			
	failed to document saccordance with NF the Inspection, Testi Water-Based Fire Pr Edition, Section 5.2 sprinkler systems sh ensure that they are normal water supply Section 5.1.2 states connections shall be maintained in accord 13.1.1.2 states Table inspection, testing a valve components at records shall be mad and maintenance of components and sha authority having jur deficient practice co and visitors. Findings include: Based on record rev p.m. on 11/26/24 wi monthly dry sprinkle documentation for 1 12-month period wa addition, monthly in all sprinkler system of the most recent 1: available for review requested on several the survey, had still interview at the time	iew and interview, the facility prinkler system inspections in PA 25. NFPA 25, Standard for ing, and Maintenance of rotection Systems, 2011 4.1 states gauges on wet pipe all be inspected monthly to in good condition and that is pressure is being maintained. It walves and fire department inspected, tested, and dance with Chapter 13. Section in the 13.1.1.2 shall be utilized for indicate maintenance of valves, and trim. Section 4.3.1 states de for all inspections, tests, the system and its lib be made available to the inspection upon request. This is uld affect all residents, staff, it was for the most recent is not available for review. In spection documentation for control valves for 12 months 2-month period was not in these documents were in occasions, but by the end of not been provided. Based on the of record review, the or acknowledged sprinkler	K 0353	K353 Sprinkler System – Maintenance and testing The facility requests paper compliance for this citation. This Plan of Corre is the center's credible allegation of compliance. Preparation and/or execution of this placorrection does not constitute admission or agreement by provider of the truth of the alleged or conclusions set in the statement of deficiencies. The plan of correction is prepared and executed solely because it required by the provisions federal and state law. Immediate actions taken for those residents identified: ="" span=""> ="" span=""> ="" span=""> Maintenance Director complete inspection of dry sprinkler sy gauges along with an inspection of dry sprinkler sy gauges along with an inspection of the sprinkler system contivatives with no concerns note ="" span=""> ="" span="">How the facility identified other residents who could be affected: ="" span="">Maintenance didid a complete audit of all gate in the sprinkler and the span="" of all gate in the span=" of all gate in the span="" of all gate in the span=" of all gate in the span="" of	eted vstem ction eted vstem ction crol eed.

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155702	(X2) MULTIPLE C A. BUILDING B. WING	Onstruction O1	(X3) DATE SURVEY COMPLETED 11/26/2024
	PROVIDER OR SUPPLIE	R	1850 \	ADDRESS, CITY, STATE, ZIP COD WEST MATADOR ST , IN 46970	
APERIO (X4) ID PREFIX TAG	SUMMARY (EACH DEFICIE REGULATORY O system gauge and o documentation for periods was not ma This finding was re	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION control valve inspection the aforementioned monthly ade available for review. eviewed with the Administrator ce Director the exit conference	PERU ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY) and valves concerning our sprinkler system with no concerns noted. ="" span=""> ="" span=""> "" span="" span=""> "" span="" span	ions e o s are ive rector dit sure s to
K 0363 SS=E Bldg. 01	failed to ensure 1 of provided with a mo	ion and interview, the facility of over 100 corridor doors were eans suitable for keeping the or impediment to closing,	K 0363	="" span=""> ="" span=""> span=""> ="" span=""> ="" span=""> ="" b=""> b=""> ="" b=""> K363 Corridor doors The facility requests paper compliance for this citation. This Plan of Corre	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE C	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	01	COMPLETED
		155702	B. WING		11/26/2024
			STREET	ADDRESS, CITY, STATE, ZIP COD	
NAME OF I	PROVIDER OR SUPPLIEF	₹		WEST MATADOR ST	
∧DEDI∩I	N CARE PERU			, IN 46970	
AFERIO	N CARE FERU		FERO	, 111 40970	
(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 DEFICIENCY)	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	_	l resist the passage of smoke.		is the center's credible	
	_	tice could affect 6 residents, 10		allegation of	
	staff, and 2 visitors	•		compliance. Preparation	
				and/or execution of this plan	
	Findings include:			correction does not constitu	
				admission or agreement by t	
		ons made on 11/26/24 at 9:30		provider of the truth of the fa	
		the facility, the corridor door to		alleged or conclusions set for	orth
		by room located off the main		in the statement of	
		in the open position with a		deficiencies. The plan of	
	_	l on observations made during		correction is prepared and/o	
	1	at 12:30 p.m., the Physical		executed solely because it is	
	Therapy entry door was still being held in the			required by the provisions o	f
		hand weight at the beginning		federal and state	
		Based on interview at the time		law. 1) Immediate actions	
		Maintenance Director		taken for those residents	
	_	aforementioned corridor door		identified:Facility Maintenan	
		rapy area as an area where		director removed hand weigh	nt
		lace and that the entry door off		from the therapy room door	
		corridor was being held open position with a hand		that was being propped	
	weight.	open position with a hand		open. 2) How the facility identified other	
	weight.			residents:Maintenance direc	.tor
	This finding was re	viewed with the Administrator		did a complete facility audit	
		ce Director the exit conference		ensure no other doors were	10
	on 11/26/24.	be Director the exit conference		propped open with no	
	OH 11/20/27.			concerns found.	
	3.1-19(b)			3) Measures put into place	-e/
				System changes:All staff we	
				re-educated on not	
				inappropriately propping ope	_{en}
				doors. Maintenance	
				Director/designee will make	
				monthly checks to ensure th	at
				any doors are not	
				inappropriately propped ope	en. │
				Checks will be added to the	
				monthly maintenance logs.	
				4) How the corrective	
				actions will be monitored:=""	п

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155702	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 11/26/2024
	PROVIDER OR SUPPLIEF		1850 V	ADDRESS, CITY, STATE, ZIP COD WEST MATADOR ST , IN 46970	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	(X5) COMPLETION DATE
				span=""> Maintenance Director/desig will conduct an audit throug his prevenative maintenanc program to ensure complia and report results to QAA meetings to ensure ongoing compliance.	gh ce nce
K 0374 SS=E Bldg. 01	NFPA 101 Subdivision of Bui Barrie	lding Spaces - Smoke			
	failed to ensure 1 or would restrict the m 20 minutes. LSC 19 barriers shall comp. 8.5.4.1 requires doc the opening leaving necessary for prope practice could affect staff and 2 visitors. Findings include: Based on observation p.m. during a tour of Maintenance Direct between resident row #129 did not fully of when tested on three was a three-foot gap closed to their fulle the time of observations of the properties of the	ons made on 11/26/24 at 12:52 If the facility with the or, the set of barrier doors om #127 and resident room lose or latch into the doorframe e separate occasions. There o between the doors when st. Based on interview during tions, the Maintenance ged these barrier doors did not the to north door rubbing on the the would have them looked	K 0374	K374 subdivision of buildin spaces-smoke barrier The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plat correction does not constituate admission or agreement by provider of the truth of the falleged or conclusions set in the statement of deficiencies. The plan of correction is prepared and/executed solely because it required by the provisions federal and state law. 1) Immediate actions taken for those residents identified:Maintenance diremade adjustments to ensur the smoke barrier door clos and latched appropriately. 2) How others having the potential to be affected will identified and what corrections.	ection In of ute the facts forth or is of

PRINTED: 12/18/2024 FORM APPROVED OMB NO. 0938-039

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER			A. BUILDING 01			COMPLETED	
		155702	B. WING 11/26/2024				
	NAME OF PROVIDER OR SUPPLIER APERION CARE PERU			REET ADDRESS, CITY, STATE, ZIP (50 WEST MATADOR ST ERU, IN 46970	COD		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF COI	RRECTION	(X5)	
PREFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL	PREF		SHOULD BE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION	TA	G DEFICIENCY)		DATE	
		ce Director the exit conference		will be taken:			
	on 11/26/24.			span=""> ="" span="">			
	3.1-19(b)			Maintenance Directo	r did a		
	3.1 19(0)			complete audit of all			
				barrier doors through			
				facility to ensure all b			
				doors closed approp			
				latched. No other cor			
				were found. 3) Me into place/ System	asures put		
				changes:Maintenanc	e		
				Director/designee wil			
				monthly checks to er	sure that		
				any smoke barrier do	ors not		
				properly closing and	or		
				latching will be			
				repaired/replaced	مط النبيد		
				immediately. Checks added to the monthly			
				maintenance logs. 4)			
				the corrective actions			
				monitored:			
				="" span="">			
				Maintenance Director			
				designee will conduc			
				through his preventa			
				maintenance progran			
				results to QAA meeti	•		
				ensure ongoing com	-		
					•		
K 0511	NFPA 101						
SS=E	Utilities - Gas and	d Electric					
Bldg. 01	1) Rased on observ	vation and interview, the facility	V 0511	K511 Utilities Gas ar	ad alastria	12/05/2024	
		of 1 electrical wiring in the	K 0511	The facility requests		12/05/2024	
		oset was protected. NFPA 70,		compliance for this	paper		
	_	cle 406.5 (F) Exposed Terminals,		citation. This Plan of	Correction		
		be enclosed so that live wiring		is the center's credib			

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

Event ID:

NJNM21 Facility ID: 003130

If continuation sheet

Page 14 of 20

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO			(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUIL		01	COMPLETED 11/26/2024	
155702			B. WING 11/26/2024				
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
					EST MATADOR ST		
APERIO	N CARE PERU		PERU, IN 46970				
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	CY MUST BE PRECEDED BY FULL		REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		1
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE	
		posed to contact. This			allegation of		
	•	ould affect as many as 2			compliance. Preparation		
	residents, 6 staff an	d 2 visitors.			and/or execution of this plan		
	Findings :11				correction does not constitu		
	Findings include:				admission or agreement by t		
	Dagad on abasement	one made on 11/26/24 at 12:26			provider of the truth of the fa		
		ons made on 11/26/24 at 12:36			alleged or conclusions set for	orun	
		of the facility with the tor, the "uniform closet" just			in the statement of		
		ce lobby had an electric box			deficiencies. The plan of	_	
		out the cover was missing a			correction is prepared and/o executed solely because it is		
		_			required by the provisions o		
	screw leaving the 12-gauge high voltage wires therein exposed. Based on interview at the time of				federal and state	'	
	observation, the Ma				law. 1) Immediate actions		
		aforementioned condition and			taken for those residents		
	_	osed wiring was visible adding			identified:The missing screw	,	
	_	the cover screw replaced as			was replaced on the cover o		
	soon as he could.	the cover serew replaced as			the electric / junction box in	'	
	soon as no coura.				the uniform closet. The elect	ric	
	This finding was re	viewed with the Administrator			panel was immediately locke		
	_	e Director the exit conference			2) How the facility	, 	
	on 11/26/24.				identified other		
					residents: Maintenance direc	ctor	
	3.1-19(b)2) Based of	on observation and interview,			did a complete audit of the		
		ensure all electrical panels in			building to ensure no other		
	the main hall were	secured from non-authorized			exposed wires were present	in	
	personnel. NFPA 7	0, 2011 edition states 230.62			any other area of the building		
	Energized parts of s	service equipment shall be			as well as an audit to ensure		
	enclosed as specifie	ed in 230.62(A) or guarded as			all electric panels were locke	ed	
	specified in 230.620				with no other concerns foun	d.	
	` ′	gized parts shall be enclosed			3) Measures put into plac	e/	
	-	t be exposed to accidental			System changes:Maintenand	e	
		guarded as in 230.62(B).			Director/designee will		
		gized parts that are not enclosed			complete monthly checks to		
		a switchboard, panelboard, or			ensure that there are no		
	_	uarded in accordance with			exposed wires and to ensure		
		Where energized parts are			all electrical boxes are locke		
		d in 110.27(A)(1) and (A)(2), a			Theses checks will be added	l to	
	_	or sealing doors providing			monthly preventative		
	access to energized	parts shall be provided. This			maintenance log. 4) How		

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	î ´	LE CONSTRUCTION	ľ ′	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDII	NG <u>01</u>		PLETED 6/2024	
155702			B. WING			6/2024	
NAME OF P	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD				
APERION	N CARE PERU		1850 WEST MATADOR ST PERU, IN 46970				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN (OF CORRECTION	(X5)	
PREFIX	`	CY MUST BE PRECEDED BY FULL	PREF	CROSS-REFERENCED TO	TION SHOULD BE THE APPROPRIATE	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION	TA	_		DATE	
	_	ould affect 40 residents and		the corrective act			
	staff.			monitored:="" b=" Maintenance Dire			
	Findings include:			will conduct an au his preventative n	udit through		
	Based on observation	on with Maintenance Director		program to ensur			
		p.m., the electrical panel next to		and report results	-		
		was unlocked. This left the		meetings to ensu			
	electrical panel unse	ecured and accessible by		compliance.			
	_	nnel. Based on interview at the					
		, the Maintenance Director					
		electrical panel was unsecured					
	and locked the pane	el at the time of observation.					
	The finding was die	cussed with the Executive					
		enance Director at exit					
	conference.	chance Director at exit					
	3.1-19(b)						
K 0781	NFPA 101						
SS=E	Portable Space H	eaters					
Bldg. 01							
		on and interview; the facility	K 0781	K781 Portable spa	ace heaters	12/05/2024	
		of 1 portable space heaters					
	were not used in the facility. This deficient practice could affect 25 residents and 3 staff in the			The feetile	4		
	Behavioral Unit.	t 25 residents and 3 staff in the		The facility reque			
	Benavioral Unit.			compliance for th	iis citation.		
	Findings include:						
	Based on observations made with the			- 112.			
				This Plan of Corr			
		for on 11/26/24 at 12:21 p.m. facility, there was portable		center's credible	anegation of		
	~	Behavioral Unit nurse station.		compliance.			
		as not plugged into a wall					
	-	observation. Based on an					
		e of the observation, the		Preparation and/	or execution		
		or agreed that there was a		of this plan of cor			
	portable space heate	er in the Behavioral Unit and		not constitute add			

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

Event ID:

NJNM21 Facility ID: 003130

If continuation sheet Page 16 of 20

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155702		(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 11/26/2024	
	F PROVIDER OR SUPPLIE ON CARE PERU	8	1850 V	ADDRESS, CITY, STATE, ZIP COD VEST MATADOR ST IN 46970	
(X4) ID PREFIX TAG	(EACH DEFICIENT REGULATORY OF the use of portable was not allowed. This finding was referenced by the second seco	STATEMENT OF DEFICIENCIE SCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION space heaters in the facility eviewed with the Executive enance Director during the exit	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) agreement by the provider of the truth of the facts alleged conclusions set forth in the statement of deficiencies. To plan of correction is prepare and/or executed solely because it is required by the provisions of federal and statlaw.	DATE f or he d
				1) Immediate actions taker for those residents identified Maintenance director removed space heater immediately from the unit. 2) How others having the potential to be affected will be identified and what correct will be taken: Maintenance Director did a complete audit of the facility ensure no other space heater were present with no other concerns found. 3) Measures put into place System changes: All staff were re-educated on tusing space heaters with the facility. Maintenance Director/designee will make	ne dive de la company de la co

PRINTED: 12/18/2024 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION ID		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155702	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 11/26/2024	
	NAME OF PROVIDER OR SUPPLIER APERION CARE PERU			STREET ADDRESS, CITY, STATE, ZIP COD 1850 WEST MATADOR ST PERU, IN 46970			
(X4) ID PREFIX TAG	(EACH DEFICIE)	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 APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
					no space heaters are present or being used. Findings will brought to the executive director. Checks will be add to the monthly preventative maintenance logs.	be	
					4) How the corrective actions will be monitored: Maintenance Director/designee will conduan audit through his preventative maintenance program to ensure complian and report results to QAA meetings to ensure ongoing compliance.	ıce	
K 0920 SS=E Bldg. 01	Extens Based on observation failed to ensure the adaptors as a substrequires electrical accordance with N Code. NFPA 70, 2 requires that, unless cords and cables slip for fixed wiring of practice could affer Findings include:	ton and interview, the facility of facility did not used multi-plug itute for fixed wiring. LSC 9.1.2 wiring and equipment shall be in FPA 70, National Electrical 011 Edition, Article 400.8 as specifically permitted, flexible hall not be used as a substitute a structure. This deficient ct 2 residents and staff.	K 0'	920	K920 Electrical equipment – power cords and extensions The facility requests paper compliance for this citation. This Plan of Correct is the center's credible allegation of compliance. Preparation and/or execution of this plan correction does not constituadmission or agreement by provider of the truth of the falleged or conclusions set for in the statement of	tion of tte the acts	12/05/2024

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

Event ID:

 $NJNM21 \hspace{0.5cm} \textit{Facility ID:} \hspace{0.5cm} 003130$

If continuation sheet

Page 18 of 20

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155702		X2) MULTIPLE CONSTRUCTION A. BUILDING D1 COMPLETED 11/26/2024			ETED		
NAME OF PROVIDER OR SUPPLIER APERION CARE PERU			STREET ADDRESS, CITY, STATE, ZIP COD 1850 WEST MATADOR ST PERU, IN 46970				
(X4) II PREFI TAC	X (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 APPROPRIA DEFICIENCY)	.TE	(X5) COMPLETION DATE
	tour of the facility on 11/26/24 betwee following was note a) resident room 13 adaptor powering of b) the employee br adapter powering a Based on interview the Maintenance D adaptor were in use employee breakroom. This finding was re-	with the Maintenance Director en 12:16 p.m. and 2:00 p.m., the ed: 81 contained a multi-plug christmas lights eakroom contained a multi-plug microwave and a box fan v at the time of observations, irector agreed mulit-plug e in the resident room 131 and			deficiencies. The plan of correction is prepared and/o executed solely because it is required by the provisions of federal and state law. 1) Immediate actions taken for those residents identified:Maintenance direct removed the multiplug adapt from room 131 as well as removed the multiplug adapt in the break room. 2) How others having the potential the affected will be identified and what corrective will be taken:Maintenance Director a complete audit of the facility to ensure no other multiplug adapters were present and removed all the multiplug adapters that were found. 3) Measures put into pla System changes:All staff were-educated on not using multiplug adapters within the facility. Maintenance Director/designee will make monthly checks to ensure the no multiplug adapters are present. Findings will be brought to the executive director. Checks will be add to the monthly maintenance logs. 4) How the corrective actions will be monitored: Maintenance Director/designee will conduct an audit through his preventative maintenance program to ensure complianted.	tor ter ter o did tty ce/ re e at	

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

Event ID:

NJNM21 Facility ID: 003130

If continuation sheet Page 19 of 20

PRINTED: 12/18/2024 FORM APPROVED OMB NO. 0938-039

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>01</u>			COMPLETED	
		155702	B. WING			11/26/2024		
NAME OF PROVIDER OR SUPPLIER APERION CARE PERU			STREET ADDRESS, CITY, STATE, ZIP COD 1850 WEST MATADOR ST PERU, IN 46970					
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	1	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	-	DATE	
					and report results to QAA meetings to ensure ongoing compliance.			

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: NJNM21 Facility ID: 003130 If continuation sheet Page 20 of 20