STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155572			(X2) MULTIPLE C A. BUILDING B. WING	B. WING 09/23/202		
	PROVIDER OR SUPPLIEI		10352	ADDRESS, CITY, STATE, ZIP COD N 600 E COUNTY LINE RD TTE, IN 46310		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)	(X5) COMPLETION DATE	
F 0000	NEGGE.TIGHT G					
Bldg. 00	-		F 0000			
	Census Bed Type: SNF/NF: 78 SNF: 4 Residential: 5 Total: 87					
	Census Payor Type Medicare: 2 Medicaid: 35 Other: 45 Total: 82	:				
	These deficiencies accordance with 41	reflect State Findings cited in 0 IAC 16.2-3.1.				
	Quality review con	pleted on 9/30/24.				
F 0554 SS=D Bldg. 00	483.10(c)(7) Resident Self-Adr	nin Meds-Clinically Approp				
		on, record review, and ty failed to ensure residents	F 0554	Tag number: F554 Med Self Admin	11/01/2024	
LABORATO	RY DIRECTOR'S OR PRO	VIDER/SUPPLIER REPRESENTATIVE'S S	IGNATURE	TITLE	(X6) DATE	
Deana Joi	rdan Collins		Regiona	l Nurse Consultant	10/29/2024	

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclodays 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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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155572	B. WI	NG		09/23/	/2024
				·			
NAME OF F	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD		
		_			N 600 E COUNTY LINE RD		
APERIO	N CARE DEMOTTE	<u> </u>		DEMOT	ΓΤΕ, IN 46310		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DROVIDED'S DI AN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	16	DATE
	were assessed for so	elf-administration of			I. What corrective action(s) wil	l be	
	medications and ha	d a Physician's Order to			accomplished for those reside		
	self-administer med	lications, for 2 of 2 residents			found to have been affected b		
		dministration of medication.			deficient practice; Resident 9 l	•	
	(Residents 9 and 32	2)			a medication self-administration		
					completed on 9/25/24. Reside		
	Findings include:				32 had no adverse reactions		
					related to the alleged deficient		
	1. During a medication pass observation on				practice.		
	9/19/24 at 11:12 a.m., LPN 1 was observed				II. How other residents having	the	
	preparing Resident 9's medications. The nurse				potential to be affected by the		
	indicated the resident was to have a nebulizer				same deficient practice will be		
	breathing treatment. She poured a plastic vial of				identified and what corrective		
	ipratropium-albuterol (medication to help control				action(s) will be taken; All		
		ng disease) 3 ml (milliliters)			residents have the potential to	be	
		attached to an oxygen mask.			affected by the alleged deficie		
	_	oxygen mask over the			practice. A full house audit wa		
	_	ed on the treatment machine,			completed to ensure any resid		
		at to take a few deep breaths.			who self-administers meds ha		
		sident she would be back in to			timely medication		
	remove the breathir	ng treatment in about 10			self-administration assessmer	nt	
		then proceeded to leave the			completed. LPN 1 was educat		
		ack to the medication cart to			on the policy for medication		
	prepare the next res	sident's medication.			self-administration.		
					III. What measures will be put	into	
	The LPN was not o	bserved checking the			place and what systemic chan		
		aturation or lung sounds prior			will be made to ensure that the	-	
		e nebulizer treatment. During			deficient practice does not rec		
	1	eaving the resident's room, the			DON/designee to educate nur		
		did not check his oxygen			on the policy "Medication		
		ounds. She was unaware if			Administration General		
		elf-administration assessment			Guidelines." To include medica	ation	
		ther indicated she did not			self-administration assessmen		
	_	e resident's rooms while they			IV. How the corrective action(s		
	1	breathing treatments.			will be monitored to ensure the	•	
					deficient practice will not recur		
	Record review for I	Resident 9 was completed on			i.e., what quality assurance		
		n. Diagnosis included, but were			program will be put into place;		
		ertension, anxiety, and dyspnea			DON/designee will audit all ne		
	(shortness of breath				admissions/re-admission to		
	I \	/	1		1		I

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Event ID:

QF3L11 Facility ID: 000471

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUP		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	LETED
		155572	B. WI	NG		09/23	/2024
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIER	R			N 600 E COUNTY LINE RD		
APERION	N CARE DEMOTTE	<u> </u>			TTE, IN 46310		
(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 APPROPRIA	ATE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	m	e de la la			ensure any resident who is at	ole to	
		any indication there was a			self-administer meds has an		
	Physician's Order o				assessment completed. Audit		
		assessment completed for the			will be completed 5x week x 4		
		ninister his breathing treatment			weeks, 2x week x 4 weeks, th	en	
	without supervisior	1.			weekly x 4 months.		
	D :				The results of these audits wil		
	During an interview on 9/19/24 at 11:44 a.m., the				reviewed in Quality Assurance		
	-	ident of Operations indicated			Meeting monthly for 6 months	or	
		not to be left alone during a			until an average of 90%		
	breathing treatment unless they had a Physician's				compliance or greater is achie		
	Order and a self-administration assessment				x4 consecutive weeks. The C		
	completed.				Committee will identify any tre	enas	
	A malion 4:41 - 1 113.T	shalizan Madiantias			or patterns and make	_	
		ebulizer-Medication			recommendations to revise th		
	· ·	nd received as current from the			plan of correction as indicated	1.	
	-	indicated, "4. Obtain baseline			Date of compliance: 11/1/24		
		ate and lung sounds" "12. ent for the treatment unless the					
		ent for the treatment unless the ssessed and authorized to					
		. On 9/17/24 at 10:49 a.m.,					
		oserved walking out of her					
		ed. There was a medication cup					
	The state of the s	contained 4 pills. One bottle					
		y and one bottle of Fluticasone					
		sion (a nasal spray for					
		eled with Resident 32's name,					
	• /-	her bathroom counter. The					
		he nurse left the pills for her					
		nat she administered her own					
	nasal sprays.						
	Resident 32's record	d was reviewed on 9/17/24 at					
	1:18 p.m. Diagnos	es included, but were not					
	limited to, obsessive-compulsive disorder,						
	hypothyroidism, an	-					
	An Annual Minimum Data Set (MDS) assessment,						
		cated the resident was					
	cognitively intact.	carea the resident was					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	00	COMPL	
		155572	B. WI	_		09/23/	ZUZ4
NAME OF P	PROVIDER OR SUPPLIER	t			ADDRESS, CITY, STATE, ZIP COD		
APERION	N CARE DEMOTTE				N 600 E COUNTY LINE RD TE, IN 46310		
(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 DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	12/4/2023, indicater resident and determ self-administer support of the Physician's Order self-administer support of the Physician's Order self-administer support of the Physician's Order self-administration or Fluticasone Proport of Pouring an interview indicated she left 4 residents' dresser are was told the resident medications were kert medication, fluvox	of prescribed oral medications					
	Regional VP of Operassessment to self-a every 6 months, and be left at the bedsid policy. A policy titled, "Med General Guidelines the facility on 9/19/are allowed to self-specifically authorizand in accordance was self-administration resident is always of ensure was completed."	of medications" "16. The bserved after administration to ely ingested. If only a partial s noted on the MAR, and					

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PRINTED: 11/13/2024 FORM APPROVED

CENTERS FOI	R MEDICARE & MEDIC	CAID SERVICES					OMB NO. 0938-039	
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	JLTIPLE C	ONSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPL	LETED	
		155572	B. WI	NG		09/23	/2024	
NAME OF I				STREET	ADDRESS, CITY, STATE, ZIP COD			
NAME OF I	PROVIDER OR SUPPLIEF	· ·		10352	N 600 E COUNTY LINE RD			
APERIO	N CARE DEMOTTE			DEMO	TTE, IN 46310			
(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	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	3.1-11(a)							
F 0610	483.12(c)(2)-(4)							
SS=D		nt/Correct Alleged Violation						
Bldg. 00	invoctigato/i rovol	The Correct / Moged Violation						
•	Based on record rev	view and interview, the facility	F 06	510	Tag number: F610		11/01/2024	
	failed to ensure a re	esident involved in a physical			Investigate/Prevent/Correct			
	altercation with and	other resident received			Violation			
		v up care for 1 of 3 residents			I. What corrective action(s) will	ll be		
	reviewed for abuse.	. (Resident 136)			accomplished for those reside			
					found to have been affected b	•		
	Finding includes:				deficient practice; Resident 13			
					was discharged from the facili	ty on		
		for Resident 136 was reviewed			9/8/24			
		a.m. The resident was admitted			II. How other residents having	the		
	1	23/24 and discharged to home			potential to be affected by the			
		es included, but were not			same deficient practice will be	!		
	_	ried dementia, hypertension and			identified and what corrective			
	_	ded on the locked memory care			action(s) will be taken; All			
	unit.				residents have the potential to			
	The Admission Mis	nimum Data Set assessment,			affected by the alleged deficie	nı		
		cated the resident had severe			practice. III. What measures will be put	into		
	cognitive impairme				place and what systemic chan			
					will be made to ensure that the	-		
	An IDOH (Indiana	Department of Health) Facility			deficient practice does not rec			
		dated 9/5/24, indicated another			Administrator/designee to edu			
	_	iched Resident 136 and struck			SSD on completing psychosog			
		es. The residents were			assessments after an altercati			
	immediately separa	ated and assessed for injuries.			with another resident			
		was sent to the hospital for			IV. How the corrective action(s	s)		
		rs to be evaluated, and			will be monitored to ensure the			
		o be monitored for signs of			deficient practice will not recur	r		
	psychosocial distres	ss.			i.e., what quality assurance			
					program will be put into place;			
		mentation the resident had			Administrator/designee will au	dit		
		psychosocial distress			for a psychosocial assessmen	nt		
	following the incide	ent. The resident was			being completed after an			

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discharged to home on 9/8/24.

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allegation of an altercation. Audits will be completed 5x week x 4

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STATEMEN	T 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	LETED
		155572	B. W	NG _		09/23/	/2024
		l .		STREET /	ADDRESS, CITY, STATE, ZIP COD	——	
NAME OF P	ROVIDER OR SUPPLIER	8			N 600 E COUNTY LINE RD		
∧ DEDI∩N	N CARE DEMOTTE				TTE, IN 46310		
AFERIO	V CARE DEWOTTE	•		DEIVIO	11E, 111 40310		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	-	on 9/19/24 at 10:37 a.m., the			weeks, 2x week x 4 weeks the	en	
		ctor indicated residents were			weekly x 4 months.		
	_	l for 72 hours after an			The results of these audits wil		
	altercation for psychosocial distress. For some				reviewed in Quality Assurance		
		ad not been triggered and he			Meeting monthly for 6 months	or	
	was not monitored	after the altercation.			until an average of 90%		
					compliance or greater is achie		
		Prevention and Reporting"			x4 consecutive weeks. The Q		
		d and did not have specific			Committee will identify any tre	nds	
	guidelines for moni	toring psychosocial distress.			or patterns and make		
					recommendations to revise the		
3.1-28(d)				plan of correction as indicated			
				Date of compliance: 11/1/24			
E 0000	400 45()(0) (0)(0						
F 0623	483.15(c)(3)-(6)(8						
SS=D	Notice Requireme						
Bldg. 00	Transfer/Discharg						11/01/0001
		view and interview, the facility	F 06	523	Tag number: F623		11/01/2024
	failed to ensure a re				Transfer/Discharge		
		vere notified in writing related			I. What corrective action(s) will		
		nospital for 1 of 3 residents			accomplished for those reside		
	reviewed for hospit	alization. (Resident 27)			found to have been affected b	-	
	F' 1' ' 1 1				deficient practice; Resident 27		
	Finding includes:				no adverse outcomes related	to	
	D 11 (27)	1 0/19/24			the alleged deficient practice.		
		d was reviewed on 9/18/24 at			II. How other residents having	tne	
		s included, but were not limited			potential to be affected by the		
		nellitus and elevation of levels			same deficient practice will be		
	of liver transaminas	se levels (liver enzymes).			identified and what corrective		
	The Operation No. 1	maxima Data Sat (MDS)			action(s) will be taken; All resi		
	•	mum Data Set (MDS)			have the potential to be affect		
		/23/24, indicated the resident			by the alleged deficient practic		
		paired for daily decision			Moving forward family/RP will		
	making.				notified of all resident transfer	5 10	
	A Ninggad Ni-4- 14	ad 7/12/24 at 6:47			hospital	into	
	A Nurses' Note, dated 7/12/24 at 6:47 p.m.,				III. What measures will be put		
	indicated the Physician was in to see the resident and new orders to send the resident to the				place and what systemic chan	-	
					will be made to ensure that the	-	
	_	ned due to elevated liver			deficient practice does not rec		
1	i enzymes ine kesn	OUSIDIE PARTY WAS HOULIEG AND	1		DON/designee to educate nur	sind	1

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED
		155572	B. WING		09/23/2024
			STREET.	ADDRESS, CITY, STATE, ZIP COD	
NAME OF P	ROVIDER OR SUPPLIER	L		N 600 E COUNTY LINE RD	
ΔPERI∩N	N CARE DEMOTTE			TTE, IN 46310	
AI LINIOI	4 OAKE DEWOTTE	•	_ DLIVIO		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	CROSS-REFERENCED TO THE APPROPRIA	TE COMPLETION
TAG		LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	-	the hospital. The resident was		staff on notifying family/RP on	<u> </u>
	sent with appropriat	te paperwork.	resident being transferred to the		ne
				hospital	
	A Physician Order Note, dated 7/12/24 at 6:48			IV. How the corrective action(s	s)
	p.m., indicated the resident was seen due to			will be monitored to ensure the	
		nes. The resident indicated he		deficient practice will not recui	r
		esis, but he did not inform		i.e., what quality assurance	
		tric (upper abdomen) pain		program will be put into place;	
		ch). The resident was sent to		DON/designee will audit hosp	
	the hospital.			discharges to ensure family/R	
				notifications were made. Audit	ts
	There was no documentation to indicate the State			will be completed weekly x 6	
		orm was completed and sent		months.	
	with the resident.			The results of these audits wil	
				reviewed in Quality Assurance	
		mentation to indicate the		Meeting monthly for 6 months	or
	-	ole Party had received written		until an average of 90%	
		esident's transfer to the		compliance or greater is achie	
	hospital.			x4 consecutive weeks. The Q	
				Committee will identify any tre	nds
	_	on 9/19/24 at 9:42 a.m., the		or patterns and make	
	_	ident of Operations indicated		recommendations to revise the	
		nentation related to the State		plan of correction as indicated	
		sent with the resident or to the		Date of compliance: 11/1/24	
	resident's Responsib	ole Party.			
		tice of Transfer and			
	_	d "Prior to discharge or			
		will: Notify the resident and			
	_	entative(s) of the transfer or			
	-	easons for the move in writing			
		nd manner they understand.			
	•	nd a copy of the notice to a			
	representative of the Office of the State Long-term				
	Care Ombudsman"				
	2.1.12(a)(()(A)(")				
	3.1-12(a)(6)(A)(ii)				
	3.1-12(a)(6)(A)(iii)				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		ľ	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	00	COMPLETED 09/23/2024	
		155572	B. WI	NG		09/23/	/202 4
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 10352 N 600 E COUNTY LINE RD DEMOTTE, IN 46310			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
F 0625 SS=D	483.15(d)(1)(2) Notice of Bed Hold	d Policy Before/Upon Trnsfr					
SS=D Bldg. 00	Based on record rev failed to ensure a re Responsible Party v bed-hold and reserv and upon transfer to residents reviewed factor 27) Finding includes: Resident 27's record 3:01 p.m. Diagnoses to, type 2 diabetes nof liver transaminas The Quarterly Minit assessment, dated 7, was moderately improved indicated the Physic and new orders to so hospital were obtain enzymes. The Resport was called to sent with appropriate A Physician Order 1 p.m., indicated the relevated liver enzyment had nausea and emestaff. He had epigas with palpation (touch the hospital).	view and interview, the facility sident and/or their vere sent the facility's re bed payment policy before the hospital for 1 of 3 for hospitalization. (Resident distributed and little and elevation of levels re levels (liver enzymes). The mum Data Set (MDS) (23/24, indicated the resident paired for daily decision ded 7/12/24 at 6:47 p.m., chan was in to see the resident end the resident to the med due to elevated liver consible Party was notified and the hospital. The resident was	F 00	525	Tag number: F625 Bed Hold I. What corrective action(s) will accomplished for those reside found to have been affected by deficient practice; Bed hold powas sent to RP and given to resident 27 on 10/10/24 II. How other residents having potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents have the potential to affected by the alleged deficie practice. Moving forward any resident who is discharged to hospital will be given a copy of bed hold policy III. What measures will be put place and what systemic chan will be made to ensure that the deficient practice does not rece Administrator/designee to edu SSD on when to provide a bed hold policy. IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; Administrator/designee will au discharges to ensure a bed ho policy was provided when applicable. Audits will be completed weekly x 6 months. The results of these audits will reviewed in Quality Assurance	nts y the solicy the the the into ges e ur; cate d s) e dit old	11/01/2024

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155572	B. W	ING		09/23/	2024
NAME OF D	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	KOVIDEK OK SUPPLIER	•		10352	N 600 E COUNTY LINE RD		
APERION	N CARE DEMOTTE	<u> </u>		DEMO	TTE, IN 46310		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	_	TAG	DEFICIENCY		DATE
		policy was sent to the resident			Meeting monthly for 6 months	or	
	and/or their Respon	isible Party.			until an average of 90%		
	D	0/10/24 -4 0/42 41			compliance or greater is achie		
	During an interview on 9/19/24 at 9:42 a.m., the Regional Vice President of Operations indicated				x4 consecutive weeks. The Q		
	-	nentation related to the			Committee will identify any tre	nas	
					or patterns and make	_	
	their Responsible Pa	ng sent to the resident and/or			recommendations to revise the		
	their Responsible Pa	arty.			plan of correction as indicated	•	
	3.1-12(a)(25)(A)				Date of compliance: 11/1/24		
	3.1-12(a)(23)(A)						
F 0641	483.20(g)						
SS=A Accuracy of Assessments							
Bldg. 00	, 10001100						
5	Based on observation	on, record review, and	F 00	541	Tag number: F641 Accuracy	of	11/01/2024
		ty failed to ensure the		<i>J</i> 11	Assessments		11/01/2021
		(MDS) comprehensive		I. What corrective action(s)			
		ccurately completed related to			accomplished for those reside		
		f 25 MDS assessments			found to have been affected b		
	reviewed. (Resident	t 29)			deficient practice; Resident 2	•	
	•				MDS was modified on 9/23/24		
	Finding includes:				II. How other residents having	the	
	-				potential to be affected by the		
	Resident 29 was ob	served in bed on 9/16/24 at			same deficient practice will be		
	10:53 a.m. At the ti	me, he indicated he did not			identified and what corrective		
	need assistance with	h anything, including getting			action(s) will be taken; All		
	up into a chair. He o	did not use any type of			residents have the potential to	be	
	restraint device to h	elp hold him in place. There			affected by the alleged deficie	nt	
	were no restraints n	oted in his bed or in any			practice. A full house audit wa	S	
	wheelchairs or chair	rs in the room.			completed to ensure residents	;	
					restraint MDS was coded corr	ectly	
	Resident 29's record	d was reviewed on 9/19/24 at			III. What measures will be put	into	
		s included, but were not limited			place and what systemic chan	iges	
	to, dementia with be	ehavioral disturbance and			will be made to ensure that the	e	
	vascular dementia.				deficient practice does not rec	ur;	
					MDS coordinator educated on	ļ	
	The Quarterly Mini	mum Data Set (MDS)			ensuring proper coding of	ļ	
	assessment, dated 8	/22/24, indicated the resident			restraints on an MDS.	ļ	
		act for daily decision making.			IV. How the corrective action(s	s)	
	He used a physical trunk restraint while in the				will be monitored to ensure the	e	

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155572	(X2) MULTIPLE C A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 09/23/2024
APERION	ROVIDER OR SUPPLIER		10352	ADDRESS, CITY, STATE, ZIP COD N 600 E COUNTY LINE RD TTE, IN 46310	
(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 CROSS-REFERENCED TO THE APPRODEFICIENCY)	DBE COMPLETION DATE
	supervision or touch daily living (ADLs) transfers, toileting h showers/bathing, an During an interview MDS Coordinator in	on 9/20/24 at 10:20 a.m., the adicated that the restraints and she would submit a		deficient practice will not re i.e., what quality assurance program will be put into pla MDS/designee to audit res MDS's to ensure accurate Audits will be completed or residents MDS's a week x weeks, then 1 residents MI assessment weekly x 4 mc The results of these audits reviewed in Quality Assura Meeting monthly for 6 mon until an average of 90% compliance or greater is ac x4 consecutive weeks. Th Committee will identify any or patterns and make recommendations to revise plan of correction as indicad Date of compliance: 11/1/2	e ace; idents coding in 5 8 DS onths will be ance withs or chieved e QA or trends e the ated.
F 0684 SS=D Bldg. 00	483.25 Quality of Care				
	interview, the facilit with abnormal lab reintervention for 1 of hospitalization (Res given as ordered for unnecessary medica and skin discoloration monitored for 1 of 2 non-pressure skin confidence.) 1. On 9/18/24 at 9::	on, record review, and ty failed to ensure a resident esults received timely f 3 residents reviewed for ident 68), medications were 2 of 5 residents reviewed for tions (Residents 24 and 55), ons were assessed and e residents reviewed for onditions. (Resident 37)	F 0684	Tag number: F684 QOC I. What corrective action(s) accomplished for those restound to have been affected deficient practice; Residen longer resides at the facility physician was notified of received a management of the physician's order and resident physician's order and resident of the physician's order and resident of the physician's order and resident or physicians orders. An amonitor skin discoloration of the physician was entered for resident of the physician orders. The physicians orders are physicians orders and physicians orders are physicians orders. An amonitor skin discoloration of the physicians orders are physicians orders. An amonitor skin discoloration of the physicians orders are physicians orders. The physicians orders are physicians orders are physicians or	sidents and by the t 68 no y. The esident held per lent or held order to until sident 37

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLE	ETED
		155572	B. W	ING		09/23/2	2024
		1		STREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIER	8			N 600 E COUNTY LINE RD		
APERIO	N CARE DEMOTTE	<u>:</u>			ΓΤΕ, IN 46310		
	1				, I	П	
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION 6 intravenous fluids were		TAG			DATE
		milliliters) per hour to his left			potential to be affected by the		
		eripherally inserted central			same deficient practice will be identified and what corrective	;	
	catheter, intravenou				action(s) will be taken; All		
	cameter, intravenou	is access) line.			residents have the potential to	, ho	
	The record for Resi	dent 68 was reviewed on			affected by the alleged deficie		
		. Diagnoses included, but were			practice. Physician to review a		
	not limited to, cerebral infarction, chronic kidney				resident with medications with	-	
	disease, and type 2	•			parameters to ensure they are		
	arsease, and type 2	diacetes memus.			accurate. A full house skin sw		
	The Quarterly Mini	mum Data Set (MDS)			was completed to ensure there	-	
		/30/24, indicated the resident			were no other skin concerns n	I	
		paired. The resident was			addressed.	iot	
		24 and returned to the facility			III. What measures will be put	into	
	_	sident was again hospitalized			place and what systemic chan		
		rned to the facility on 8/24/24.			will be made to ensure that the	-	
	on or to 2 rand reta	fined to the identity on 0/2 i/2 ii			deficient practice does not rec	1	
	A Care Plan, undate	ed 3/4/24, indicated the			DON/designee to educate nur		
	_	for decreased cardiac output			staff on administering medicat	-	
		illation, hyperlipidemia, and			per phsycians orders to includ		
		ntervention, dated 3/4/24,			holding medications not within		
		r lab values and report results			parameters. Nursing staff also		
	to the Physician.				educated on identifying and		
					monitoring any areas of skin		
	A Care Plan, update	ed 3/4/24, indicated the			discoloration.		
		for dehydration related to			IV. How the corrective action(s	s)	
		tervention, dated 3/26/24,			will be monitored to ensure the	<i>'</i>	
		labs and diagnostics as			deficient practice will not recui	I	
		up with Physician as indicated.			i.e., what quality assurance		
					program will be put into place;	;	
	A Nurse Practitione	er Note, dated 6/28/24 at 1:34			DON/designee will audit resid		
		resident was seen for			MARS to ensure medications	I	
	-	eported delusions, headaches,			passed and/or held per physic	ians	
		ht loss. The assessment			orders. DON/designee will aud		
		idney disease and sub-acute			weekly skin assessments to		
		e lab tests and a KUB (x-ray of			ensure any areas of discolora	tion	
		pladder) were ordered for			are monitored per policy. Aud	I	
		lab tests were ordered for			will be completed on 5 resider		
	7/1/24.				week x 8 weeks, then 1 reside		
					week x 4 months		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLETED	
		155572	B. WI	NG		09/23/	2024
				CTD FFT A	ADDRESS CITY STATE ZID COD		
NAME OF P	ROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD		
ADEDION	LOADE DEMOTTE	_			N 600 E COUNTY LINE RD		
APERIO	N CARE DEMOTTE	=		DEMOT	TE, IN 46310		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	-	DATE
	A Progress Note, d	ated 6/28/24 at 3:54 p.m.,			The results of these audits will	be	
	indicated the KUB	results and lab results were			reviewed in Quality Assurance	:	
	reported to the Nur	se Practitioner.			Meeting monthly for 6 months	or	
					until an average of 90%		
		cated the following tests were			compliance or greater is achie	ved	
		at 7:09 a.m. and reported on			x4 consecutive weeks. The Q		
	7/1/24 at 7:59 p.m.				Committee will identify any tre	nds	
	-	tabolic panel (electrolytes),			or patterns and make		
	•	bin time, blood clotting test),			recommendations to revise the		
	` •	ulating hormone), CBC			plan of correction as indicated	.	
		ount), lipid panel (cholesterol			Date of compliance: 11/1/24		
		vitamin D 25-OH, folate, vitamin					
	B12, and hemoglob	oin A1C (blood sugar levels).					
	7E) 1 1						
		f any documentation the lab					
		had been communicated with					
	the Physician or Nu	arse Practitioner.					
	A Nurse Practition	er Note, dated 7/2/24 at 3:26					
		had reviewed the 7/1/24 lab					
	*	(blood urea nitrogen, a kidney					
		vas 69 (elevated), the creatinine					
	· ·	lab test) was 3.3 (elevated), the					
	` •	(elevated), the alkaline					
	*	r function lab test) was 800					
		white blood cell count was 12					
		d spoken with the Nurse					
		ad been on call 7/1/24 and she					
		aware of these lab results.					
	The resident was to	be sent out to the Emergency					
	Room (ER) for ren	al failure.					
	A Progress Note, d	ated 7/2/24 at 3:29 p.m.,					
		Practitioner had ordered to					
	send the resident to	the ER for abnormal labs.					
		ated 7/2/24 at 3:30 p.m.,					
		peen called to transport the					
	resident to the ER.						

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	
		155572	B. W	ING		09/23/	/2024
	PROVIDER OR SUPPLIEIN		<u> </u>	10352 N	ADDRESS, CITY, STATE, ZIP COD N 600 E COUNTY LINE RD TE, IN 46310	•	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID			(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	IIE	DATE
	_	ated 7/2/24 at 3:47 p.m.,					
	· ·	nergency Medical Services) was					
	I	ne resident was going to the ER					
	for evaluation and treatment.						
	The hospital Admission History and Physical,						
		ated the resident was admitted					
		ury. The chief complaint					
		al failure and electrolyte					
		found on follow up labs.					
		n potassium) and hyponatremia					
		mild and improved with IV					
	(intravenous) hydration and the renal function						
	was also improving	5.					
	Regional Vice Pres	v on 9/18/24 at 10:50 a.m., the ident of Operations indicated the situation. No further ovided.					
		ford was reviewed on 9/18/24 at as included, but were not limited opertension.					
		imum Data Set (MDS) 3/13/24, indicated the resident act.					
	A Care Plan, dated	3/14/22, indicated the resident					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		UILDING	00	COMPL	
		155572	B. W			09/23/	ZUZ4
NAME OF I	PROVIDER OR SUPPLIEF	2			ADDRESS, CITY, STATE, ZIP COD		
APERIO	N CARE DEMOTTE	:			N 600 E COUNTY LINE RD TE, IN 46310		
	ı		1	<u> </u>	12, 111 100 10		(7/5)
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
		eased cardiac output related to					
		blood pressure). Interventions					
	included, but were medications as orde	not limited to, administer					
	medications as orde	ered.					
	A Physician's Order	r, dated 5/18/24, indicated					
	lisinopril 20 milligr	ram (mg) tablet once daily.					
	A Physician's Order, dated 5/18/24, indicated						
		e 5 mg tablet once daily.					
	A Physician's Orde	r, dated 5/18/24, indicated hold					
	-	dipine if systolic blood pressure					
	(top number) is less than 110 every shift for						
	hypotension.						
	The August and Se	ptember 2024 Medication					
		ord indicated the lisinopril and					
	-	ot held per the Physician's					
		ving dates and times:					
		n., blood pressure 106/68 m., blood pressure 109/71					
		m., the medication was not					
		blood pressure was not					
	documented	•					
		m., the medication was not					
	administered and a documented	blood pressure was not					
	documented						
	-	v on 9/19/24 at 9:42 a.m., the					
	_	ident of Operations indicated					
	he had no further in	formation to provide.					
	-	ord was reviewed on 9/18/24 at					
	_	ses included, but were not					
	and type 2 diabetes	sion, chronic kidney disease, mellitus.					
	January Para and Store						
	The Quarterly Mini	mum Data Set (MDS)					

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155572	ì í	UILDING	nstruction 00	(X3) DATE COMPL 09/23/	ETED
	PROVIDER OR SUPPLIER			10352 N	DDRESS, CITY, STATE, ZIP COD I 600 E COUNTY LINE RD TE, IN 46310		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE OF T	ATE.	(X5) COMPLETION DATE
ING	assessment, dated 8	2/26/24, indicated the resident act for daily decision making.		IAG			DAIL
		lans, indicated the resident had pertension, and received times per week.					
	was at risk for decr hyperlipidemia, hyp	5/7/24, indicated the resident eased cardiac output related to pertension, and hypotension. ded, but were not limited to, ions as ordered.					
	indicated the reside milligrams (mg) 1 o midodrine 10 mg ta	4 Physician Order Summary nt received gabapentin 100 capsule three times a day, ablet three times a day, and e 800 mg 2 tablets with meals.					
	Administration Rec	ptember 2024 Medication cord (MAR) indicated the ot administered as ordered on and times:					
	and 9/5/24 - 12:00 p.m. on 8/1 8/13, 8/15, 8/16, 8/ 9/3, 9/5, 9/7, 9/8, 9/ - 4:00 p.m. on 8/5,	8/5, 8/6, 8/10, 8/11, 8/16, 8/25, , 8/3, 8/5, 8/6, 8/8, 8/10, 8/12, 17, 8/23, 8/24, 8/27, 8/29, 8/31, /10, 9/12, 9/14, 9/17, and 9/19/24 8/10, 8/17, and 8/19/24 , 8/23, 8/25, 9/2, 9/5, 9/8, and					
		, 8/3, 8/6, 8/8, 8/10, 8/13, 8/15, 24, 8/27, 8/29, 8/31, 9/3, 9/5, 9/7, 17, and 9/19/24					

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED	
		155572	B. WING		09/23/2024	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 10352 N 600 E COUNTY LINE RD DEMOTTE, IN 46310			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	DECLIDED OF AN AN OF CORRECTION	(X5)	
PREFIX		CY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION	
TAG	•	LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE	
	8/17, 8/24, 8/27, 8/2 9/14, 9/17, and 9/19 A Physician's Order midodrine 10 mg ta systolic blood press 130. The August and Sep Administration Rec midodrine was not 1 following dates and - 8/22/24 at 9:00 a.r 8/22/24 at 12:00 p 8/28/24 at 6:00 p.r 9/12/24 at 6:00 p	8/1, 8/3, 8/6, 8/8, 8/10, 8/13, 8/15, 29, 8/31, 9/3, 9/5, 9/7, 9/10, 9/12, 0/24 c, dated 8/21/24, indicated blet three times a day, hold if ure (top number) is above otember 2024 Medication ord (MAR) indicated the held as ordered on the times: m., blood pressure 134/60 m., blood pressure 150/76 m., blood pressure 167/93 m, blood pressure 144/78 m., blood pressure 138/71 m., blood pressure 141/86 of on 9/19/24 at 9:42 a.m., the ident of Operations indicated formation to provide. action and interview on 9/16/24 cent 37 indicated she had gone to y tried to put multiple to both arms, but they were resident's bilateral forearms large discolorations. d was reviewed on 9/17/24 at s included, but were not limited kness) affecting the left and major depressive disorder				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155572		(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 09/23/2024	
	PROVIDER OR SUPPLIER		10352	ADDRESS, CITY, STATE, ZIP COD N 600 E COUNTY LINE RD TTE, IN 46310	
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	
TAG	The Quarterly Mini assessment, dated 8 was cognitively inta A Weekly Skin Obs 9/11/24 at 8:03 a.m observation was wa concerns. There we A Weekly Skin Obs 9/18/24 at 2:10 p.m observation was wa concerns. There we During an interview Regional Vice Presithere was no docum resident's record and implemented a new bilateral forearm br A policy titled, "Sk Monitoring - Pressuindicated "Non-proferiuses/contusions. healing progress and infection weekly	order for monitoring of the	TAG		DATE
F 0685 SS=D Bldg. 00	483.25(a)(1)(2) Treatment/Device	s to Maintain Hearing/Vision			
	interview, the facili received ancillary s	on, record review, and ty failed to ensure a resident ervices to maintain vision and manner, for 1 of 1 residents	F 0685	Tag number: F685 Tx/Devices/Vision/Hearing I. What corrective action(s) will accomplished for those reside	

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STATEMEN	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
		155572	B. W	NG		09/23/	/2024
				_			
NAME OF I	PROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP COD		
		_			N 600 E COUNTY LINE RD		
APERIO	N CARE DEMOTTE	<u>:</u>		DEMOI	ΓΤΕ, IN 46310		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	16	DATE
	reviewed for vision	/hearing. (Resident 27)			found to have been affected b	y the	
					deficient practice; Resident 27	has	
	Finding includes:				an appt scheduled to see the		
					optometrist on 111/5/24 and		
	During an interview on 9/16/24 at 10:43 a.m.,				audiologist on 10/23/24		
	Resident 27 indicate	ed he could not hear or see and			II. How other residents having	the	
	required outside ser	vices, however, the facility			potential to be affected by the		
	_	ing to help him with hearing or			same deficient practice will be		
	vision services at th	e time.			identified and what corrective		
					action(s) will be taken; All		
	Resident 27's record was reviewed on 9/18/24 at				residents have the potential to	be	
	3:01 p.m. Diagnoses included, but were not limited				affected by the alleged deficient		
	to, encephalopathy (brain disease), legal				practice. A full house audit wa	S	
	blindness, and hearing loss.				completed to ensure any resid	lent	
					who consented to optometry of		
	The Quarterly Mini	mum Data Set (MDS)			audiology was seen in a timely		
	assessment, dated 7	7/23/24, indicated the resident			manner or an appt was scheduled.		
	was moderately imp	paired for daily decision		III. What measures will be put into			
	making. He had mo	derate difficulty with the ability			place and what systemic chan	ges	
	to hear and did not	have hearing aids. He had			will be made to ensure that the	e	
	highly impaired vis	ion and did not have corrective			deficient practice does not rec	ur;	
	lenses.				SSD educated on scheduling	an	
					appt for any resident who		
	A Care Plan, dated	3/25/24, indicated the resident			consented to seeing optometry	y or	
	had a behavior prob	olem related to being hard of			audiology in a timely manner.		
	hearing and yelling	out and speaking loudly.			IV. How the corrective action(s	s)	
					will be monitored to ensure the	9	
	A Care Plan, dated	2/20/24, indicated the resident			deficient practice will not recu		
	had impaired comm	nunication related to hearing			i.e., what quality assurance		
	deficits.				program will be put into place;		
					SSD/designee will complete a	n	
	-	r, dated 7/26/24, indicated to			audit on all new		
		the eye doctor list for the next			admission/readmissions to en	sure	
	rounds, as he reque	sted an evaluation.			anyone consenting to audiolog	gy or	
					optometry has an appointmen	t	
	1	ces Consent for vision, hearing,			scheduled in a timely manner.		
		es, dated 2/19/24, had verbal			Audits will be conducted 5x we	eek	
	consent written for	all services.			x 4 weeks, then weekly x 5		
					months.		
	During an interview	on 9/18/24 at 3:11 p.m., the					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155572	B. WI	NG		09/23/	2024
				CTDEET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER	L.					
ADEDION	LOADE DEMOTTE				N 600 E COUNTY LINE RD		
APERIOR	N CARE DEMOTTE			DEMO	ΓΤΕ, IN 46310		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DROVIDED'S DI AN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)		COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	16	DATE
	Social Services Dire	ector (SSD) indicated the			The results of these audits will	be	
		Responsible Party had given			reviewed in Quality Assurance		
		he three ancillary services,			Meeting monthly for 6 months		
		ary Service Company indicated			until an average of 90%		
	they needed a signed consent and order to treat. Ancillary Service Company would not accept a				compliance or greater is achie	ved	
					x4 consecutive weeks. The Q		
	verbal consent to treat. The SSD indicated the				Committee will identify any tre		
	current list for the ancillary services did not				or patterns and make		
		at this time for both audiology			recommendations to revise the	÷	
		ices. The SSD assessed needs			plan of correction as indicated		
		arterly basis and would			Date of compliance: 11/1/24		
	_	e resident and/or their					
		t the next Care Plan Meeting.					
	,	S					
	During an interview	on 9/19/24 at 1:30 p.m., the					
	_	ident of Operations indicated					
	_	for ancillary services to come					
	_	dents started in March of 2024					
		f had just sent off a new					
	consent to treat with	-					
	A policy titled, "Pol	licy on On-site Health Care					
		"It is the policy of the					
		ident sin arranging health					
	•	eeded per resident request.					
		appointments for ancillary					
	-	d by resident. On-site					
	services available: .	-					
	optometry"	,					
	-F7						
	3.1-39(a)(1)						
F 0689	483.25(d)(1)(2)						'
SS=D	Free of Accident						
Bldg. 00	Hazards/Supervis	ion/Devices					
•		on, record review, and	F 06	589	Tag number: F689 Free of		11/01/2024
		ty failed to ensure fall			Accidents		-1.01.2021
		place for a resident with a			I. What corrective action(s) wil	l be	
	_	of 7 residents reviewed for			accomplished for those reside		
	accidents. (Resident				found to have been affected by		
	`	•	1		I	•	

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLETED	
		155572	B. W	ING		09/23/2024	
		<u> </u>		STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIER	8			N 600 E COUNTY LINE RD		
APERIO	N CARE DEMOTTE	1			TTE, IN 46310		
					, -		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	·	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE COMPLETION	
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE	
	F: 1: 1 1				deficient practice; Resident 21		
	Finding includes:				her nonskid strips placed in ro		
	On 9/16/24 at 10:23 a.m., Resident 21 was				II. How other residents having		
					potential to be affected by the		
		ner wheelchair near the front			same deficient practice will be	;	
		oservation of her room at that			identified and what corrective		
		e were no non-skid strips to			action(s) will be taken; All		
	the floor anywhere	in her room or bathroom.			residents have the potential to		
					affected by the alleged deficie		
		a.m., Resident 21 was assisted			practice. A full house audit wa	IS	
	by staff to her room and was seated in her				completed to ensure all fall		
	wheelchair. There were no non-skid strips			interventions were in place and			
	observed to the floor anywhere in her room or				any discrepancies corrected.		
	bathroom.				III. What measures will be put		
					place and what systemic char	-	
		dent 21 was reviewed on			will be made to ensure that the	e	
		n. Diagnoses included, but			deficient practice does not rec	eur;	
		dementia with psychotic			DON/designee to educate nur	sing	
		e obstructive pulmonary			staff on ensuring fall intervent	ions	
	disease, and anxiety	disorder.			are in place.		
					IV. How the corrective action(s)	
		S (Minimum Data Set)			will be monitored to ensure the	e	
		/15/24, indicated the resident			deficient practice will not recu	r	
		paired. She had one fall with			i.e., what quality assurance		
	1	e fall with no injury since the			program will be put into		
	prior assessment.				place;DON/designee will cond	luct	
					a fall intervention audit as follo	ows:	
	_	ed 10/23/23, indicated the			Audits will be completed on 10)	
	•	ntial for falls. An intervention,			residents at risk for falls a wee	ek	
	dated 7/22/24, indic	eated non-skid strips in front of			for 8 weeks, then 2 residents	а	
	the bed and in the b	athroom.			week x 4 months.		
					The results of these audits wil	l be	
	1	nent of Health reportable			reviewed in Quality Assurance	e	
		/24, indicated the resident was			Meeting monthly for 6 months	or	
		n the bathroom. The resident			until an average of 90%		
	indicated she had sp	pilled her drink while			compliance or greater is achie	eved	
	attempting to go to	the bathroom and slipped in			x4 consecutive weeks. The C	PΑ	
	the liquid. She com	plained of right shoulder pain			Committee will identify any tre	ends	
	and was sent to the	hospital for evaluation. She			or patterns and make		
	was found to have a	an anterior displaced fracture			recommendations to revise the	۹	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		r í	LE CONSTRUCTION	î î	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155572	A. BUILDIN B. WING	IG <u>00</u>	COMPLETED 09/23/2024	COMPLETED 09/23/2024	
		100012					
NAME OF F	ROVIDER OR SUPPLIER	1		EET ADDRESS, CITY, STATE, ZIP COD 352 N 600 E COUNTY LINE RI			
APERIO	N CARE DEMOTTE			MOTTE, IN 46310	,		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORREC	HON	X5)	
PREFIX	`	CY MUST BE PRECEDED BY FULL	PREFI	CROSS-REFERENCED TO THE APPL	COMPI	LETION	
TAG	of sternal end of rig	t LSC IDENTIFYING INFORMATION	TAC	plan of correction as indic	DA	TE	
	of sternar end of rig	nt clavicie.		Date of compliance: 11/1			
	A Fall IDT (interdis	sciplinary team) Note, dated		Bate of compilation 1171			
	· ·	n., indicated the resident had					
	attempted to transfe	r herself to the toilet and					
	slipped in iced tea that she had spilled on the						
		ed new intervention was to					
	place non-skid strips in front of the bed and toilet						
	and place lids on all	cups.					
	During an interview	on 9/18/24 at 10:50 a.m., the					
		ident of Operations indicated					
	he would review the						
		led "Fall Prevention Program,"					
	-	interventions will be					
	-	ch resident identified at					
		dent reports involving falls will					
	-	Interdisciplinary Team to care and services were					
	provided and determ						
	interventions"	mile possible safety					
	3.1-45(a)						
F 0695	400.05(:)						
SS=D	483.25(i)	eostomy Care and					
Bldg. 00	Suctioning	eostorily Care and					
Blug. 00	•	on, record review and	F 0695	Tag number: F695	11/01	/2024	
		ty failed to ensure a resident	1 0075	Resp/Trach/Suctioning	11/01	1/2024	
		ary care and treatment related		I. What corrective action(s) will be		
	to oxygen not adm	inistered as ordered or		accomplished for those re	esidents		
		residents reviewed for		found to have been affec	·		
	respiratory care. (Re	esident 7)		deficient practice; Reside			
	Dinding in the 4-			oxygen order was change	ed to		
	Finding includes:			PRN on 10/8/24 II. How other residents ha	oving the		
	On 9/17/24 at 9:44	a.m., Resident 7 was observed		potential to be affected b	-		
		er. There was an oxygen		same deficient practice w			
		her that was turned on. The		identified and what corre			

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STATEMEN	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
		155572	B. W	NG		09/23/	/2024
				CED FEET	ADDRESS OF A STATE OF COR	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD		
ADEDIO	N OADE DEMOTTE	_			N 600 E COUNTY LINE RD		
APERIO	N CARE DEMOTTE	<u>-</u>		DEMO	ΓΤΕ, IN 46310		
(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	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	oxygen tubing and	nasal cannula were lying on			action(s) will be taken; Any		
	the floor. The resid	ent indicated she only used the			resident on oxygen therapy ha	is to	
	oxygen at night.				potential to be affected by the		
					alleged deficient practice. A fu	II	
	On 9/18/24 at 11:53	3 a.m. the resident was observed			house audit was conducted or	1	
	seated in her room.	The oxygen concentrator was			any resident on oxygen therap	y to	
	off and the oxygen	tubing was in a plastic bag.			ensure their orders are accura	te.	
					III. What measures will be put	into	
	The resident's record was reviewed on 9/18/24 at				place and what systemic chan		
	10:25 a.m. Diagnoses included, but were not				will be made to ensure that the	e	
	limited to, acute and chronic respiratory failure,				deficient practice does not rec	ur;	
	diabetes mellitus, schizoaffective disorder and				DON/designee to educate nur		
	depression.				staff on following a physicians		
					order for oxygen therapy.		
	The Quarterly Minimum Data Set assessment,				IV. How the corrective action(s	s)	
	dated 8/15/24, indic	cated the resident had moderate			will be monitored to ensure the		
	cognitive deficits, r	equired substantial assistance	deficient practice will not recur				
	for transfers and mo	oderate assistance for bed			i.e., what quality assurance		
	mobility.				program will be put into place;		
					DON/designee to complete an	1	
	-	r, dated 8/31/24, indicted to			audit on residents who are on		
		at 3 liters per minute			oxygen therapy to ensure it is		
	continuously per na	sal cannula.			being utilized per physicians		
					orders. Audits will be complete		
		4 Medication Administration			on 5 residents a week x 4 wee	ks,	
	` ′	not have any documentation			2 residents a week x 4 weeks		
	related to oxygen b	eing administered or refused.			then 1 resident a week x 4		
		0/10/01 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			months.		
		v on 9/18/24 at 2:01 p.m., LPN 1			The results of these audits will		
		ent would refuse to use her			reviewed in Quality Assurance		
		only ordered as needed. She			Meeting monthly for 6 months	or	
		order was for continuous			until an average of 90%	_	
		no place on the MAR to			compliance or greater is achie		
	document if the oxy	ygen was refused or in use.			x4 consecutive weeks. The Q		
	21.45()(6				Committee will identify any tre	nds	
	3.1-47(a)(6)				or patterns and make		
					recommendations to revise the	_	
					plan of correction as indicated	-	
					Date of compliance: 11/1/24		
			1				

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	LIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SUR		SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPL	ETED
		155572	B. WI	NG		09/23/	2024
				CERE	A DDDDEGG OUTV OT ATE THE COD		
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
ABEDION	LOADE DEMOTTE				N 600 E COUNTY LINE RD		
APERION	N CARE DEMOTTE			DEMIC	OTTE, IN 46310		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
F 0698	483.25(I)						
SS=D	Dialysis						
Bldg. 00	-						
	Based on observation	on, record review, and	F 06	598	Tag number: F698 Dialysis		11/01/2024
	interview, the facili	ty failed to provide the			I. What corrective action(s) wil	l be	
	necessary care and	services for residents who			accomplished for those reside		
	received hemodialy	sis, related to not monitoring			found to have been affected b		
	the dialysis access s	ite, for 1 of 1 resident			deficient practice; Resident 23	-	
	reviewed for dialysi	is. (Resident 231)			had an order to monitor his		
	•				dialysis site entered on 10/4/2	4	
	Finding includes:				II. How other residents having		
	-				potential to be affected by the		
	On 9/16/24 at 10:19 a.m., Resident 231 was seated same deficient practice will be						
	in his wheelchair near the front Nurse's Station.				identified and what corrective		
	He had his dialysis	bag on his lap and indicated			action(s) will be taken; Any		
	he was waiting to le	eave for dialysis. He went to			resident with a dialysis cathete	er	
	dialysis on Monday	s, Wednesdays, and Fridays.			has the potential to be affected	d by	
	He had a catheter to	his right chest that was used			the alleged deficient practice.	A	
	for dialysis.				full house audit was completed	d to	
					ensure any resident with a dia	lysis	
	The record for Resi	dent 231 was reviewed on			catheter has an order to monit	or	
	9/19/24 at 11:05 a.m	n. Diagnoses included, but			site. Any discrepancies were		
	were not limited to,	end stage renal disease,			immediately corrected.		
	hypertension, and ty	pe 2 diabetes mellitus.			III. What measures will be put	into	
					place and what systemic chan	ges	
	The Admission Mir	nimum Data Set (MDS)			will be made to ensure that the	е	
	assessment, dated 7	/10/24, indicated the resident			deficient practice does not rec	ur;	
	was cognitively inta	act and received hemodialysis			DON/designee to educate nur	sing	
	services.				staff on the policy "Dialysis		
					Monitoring and Observation" to	0	
		spitalized on 9/2/24 and			include monitoring a dialysis		
	readmitted to the fa	cility on 9/13/24.			catheter.		
					IV. How the corrective action(s	s)	
	The Physician's Ord	ler Summary, dated 9/2024,			will be monitored to ensure the		
		e no current orders for			deficient practice will not recui	.	
		ident was receiving dialysis or			i.e., what quality assurance		
	•	e dialysis catheter. There were			program will be put into place;		
	•	continued on 9/3/24, for			DON/designee will audit new		
	-	d dialysis catheter monitoring.			admissions/re-admissions or a	any	
	These orders had no	ot been continued upon			resident who has a dialysis		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155572		(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 09/23/2024	
	PROVIDER OR SUPPLIER		10352	ADDRESS, CITY, STATE, ZIP COD N 600 E COUNTY LINE RD TTE, IN 46310	
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION DATE
	and Treatment Adm dated 9/2024, lacke dialysis catheter for 9/16/24, and 9/17/2 During an interview Regional Vice Presible would review the A Facility Policy, ti Observation," receiff the resident has a will assess the cathedrainage and conditievery shiftDocum dialysis catheter site	ministration Record (MAR) ninistration Record (TAR), d any monitoring of the 19/13/24, 9/14/24, 9/15/24, 4. on 9/18/24 at 10:50 a.m., the ident of Operations indicated		catheter placed to ensure the an order to monitor catheter's Audits will be completed 5x w x 4 weeks, 2x week x 4 weeks then weekly x 4 months. The results of these audits will reviewed in Quality Assurance Meeting monthly for 6 months until an average of 90% compliance or greater is achie x4 consecutive weeks. The Committee will identify any treor patterns and make recommendations to revise the plan of correction as indicated Date of compliance: 11/1/24	ite. eek s, II be e s or eved QA ends
F 0761 SS=E Bldg. 00	3.1-37(a) 483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals Based on observation and interview, the facility failed to ensure medications were properly stored for 2 of 4 medication carts observed. (ACU Cart, and West 1 Cart) Findings include: 1. On 9/20/24 at 2:33 p.m., the ACU Medication Cart was observed with Agency QMA 1. There were multiple pills of different sizes and colors that were loose and out of the packages throughout the bottoms of the drawers in the cart. The QMA indicated that was the first day she had worked on the cart.		F 0761	Tag number: F761 Label/Sto Drugs I. What corrective action(s) wi	II be
				accomplished for those resided found to have been affected by deficient practice; No resident were affected by the alleged deficient practice. II. How other residents having potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; A full house audit was completed of	by the disconnection of the di

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QF3L11

Facility ID: 000471

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	AND PLAN OF CORRECTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155572		ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 09/23/2024
	PROVIDER OR SUPPLIER N CARE DEMOTTE	10352	ADDRESS, CITY, STATE, ZIP COD N 600 E COUNTY LINE RD TTE, IN 46310	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	5.112
	2. On 9/20/24 at 2:47 p.m., the West 1 Medication Cart was observed with RN 2. There were multiple pills of different sizes and colors that were loose and out of the packages throughout the bottoms of the drawers in the cart. The RN indicated that nursing was responsible to clean the carts. During an interview on 9/20/24 at 2:45 p.m., the Assistant Director of Nursing indicated the Director of Nursing was usually responsible to make sure the carts were cleaned. 3.1-25(j) 3.1-25(o)		medication carts to ensure the are free from loose medication III. What measures will be put place and what systemic chan will be made to ensure that the deficient practice does not recomposed by the deficient practice does not recomposed by the deficient practice does not recomposed by the deficient practice of debris. IV. How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; DON/designee to audit medical carts to ensure they are free folioose medications/debris. Aud will be completed weekly x 6 months. The results of these audits will reviewed in Quality Assurance Meeting monthly for 6 months until an average of 90% compliance or greater is achied at a consecutive weeks. The Committee will identify any tree or patterns and make recommendations to revise the plan of correction as indicated Date of compliance: 11/1/24	into ges e ur; sing arts ation rom its I be e or eved A nds e
F 0773 SS=D Bldg. 00	483.50(a)(2)(i)(ii) Lab Srvcs Physician Order/Notify of Results			
	Based on observation, record review, and interview, the facility failed to ensure abnormal lab results were reported to the Physician for 1 of 3 residents reviewed for hospitalization (Resident 68).	F 0773	Tag number: F773 I. What corrective action(s) will accomplished for those reside found to have been affected by deficient practice; The provides	nts y the

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155572	B. W	NG	_	09/23/	2024
				_	_		
NAME OF I	PROVIDER OR SUPPLIEF	3			ADDRESS, CITY, STATE, ZIP COD		
					N 600 E COUNTY LINE RD		
APERIO	N CARE DEMOTTE	<u> </u>		DEMOT	ΓΤΕ, IN 46310		
(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	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	-	DATE
					was notified of the residents		
Finding includes:				abnormal lab values.			
				II. How other residents having	the		
	On 9/18/24 at 9:31	a.m., Resident 68 was observed			potential to be affected by the		
	lying in bed with hi	is eyes closed. Normal Saline			same deficient practice will be	:	
	0.9% intravenous fl	luids were infusing at 100 ml			identified and what corrective		
	(milliliters) per hou	r to his left upper arm PICC			action(s) will be taken; All		
		ed central catheter, intravenous			residents have the potential to	be	
	access) line.				affected by the alleged deficie		
	ĺ				practice. Moving forward, the		
	The record for Resi	ident 68 was reviewed on			provider will be notified timely	of	
	9/18/24 at 9:43 a.m	. Diagnoses included, but were			any abnormal lab		
		bral infarction, chronic kidney		III. What measures will be put into			
	disease, and type 2	-			place and what systemic chan		
	, ,,				will be made to ensure that the	•	
	The Quarterly Mini	imum Data Set (MDS)			deficient practice does not recur;		
		3/30/24, indicated the resident	DON/designee to educate nurses				
		paired. The resident was		on timely notification to the			
		and returned to the facility on			provider of any abnormal labs		
	_	ent was again hospitalized on			IV. How the corrective action(s		
		ed to the facility on 8/24/24.			will be monitored to ensure the	,	
		•			deficient practice will not recui		
	A Care Plan, update	ed 3/4/24, indicated the			i.e., what quality assurance		
	_	for decreased cardiac output			program will be put into place;		
		rillation, hyperlipidemia, and			DON/designee will audit lab		
		ntervention, dated 3/4/24,			results to ensure any abnorma		
		or lab values and report results			labs were reported to the prov		
	to the Physician.	1			timely Audits will be completed		
					5xweek x 4 weeks, 2x week x		
	A Care Plan, update	ed 3/4/24, indicated the			weeks then weekly x 4 weeks		
		for dehydration related to			The results of these audits wil		
		tervention, dated 3/26/24,			reviewed in Quality Assurance		
		labs and diagnostics as			Meeting monthly for 6 months		
		up with Physician as indicated.			until an average of 90%		
		. ,			compliance or greater is achie	eved	
	A Nurse Practitions	er Note, dated 6/28/24 at 1:34			x4 consecutive weeks. The Q		
	p.m., indicated the resident was seen for						
	l -	eported delusions, headaches,			Committee will identify any trends or patterns and make		
		tht loss. The assessment			recommendations to revise the	_	
		idney disease and sub-acute			plan of correction as indicated		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	00	COMPL	ETED
		155572	B. W	ING		09/23/	2024
				CTREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIEF				1 600 E COUNTY LINE RD		
ADEDION	U CADE DEMOTTE						
APERIO	N CARE DEMOTTE			DEMOT	TE, IN 46310		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	cholecystitis. Some	e labs and a KUB (x-ray of the			Date of compliance: 11/1/24		
	kidney, ureter, blad	der) were ordered for 6/28/24					
	and repeat labs wer	e ordered for 7/1/24.					
	1 -	ated 6/28/24 at 3:54 p.m.,					
		results and lab results were					
	reported to the Nurs	se Practitioner.					
		cated the following labs tests					
		/1/24 at 7:09 a.m. and reported					
	on 7/1/24 at 7:59 p.						
		abolic panel (electrolytes),					
		oin time, blood clotting test),					
		lating hormone), CBC					
		unt), lipid panel (cholesterol					
		vitamin D 25-OH, folate, vitamin					
	B12, and nemoglob	in A1C (blood sugar levels).					
	There was look of a	ny documentation the lab					
		had been communicated with					
	the Physician or Nu						
	the Thysician of Tva	rise Tractitioner.					
	A Nurse Practitione	er Note, dated 7/2/24 at 3:26					
		had reviewed the 7/1/24 lab					
	1 ~	blood urea nitrogen, a kidney					
		as 69 (elevated), the creatinine					
	1	ab test) was 3.3 (elevated), the					
	I ' -	(elevated), the alkaline					
	1 -	r function lab test) was 800					
		white blood cell count was 12					
	(elevated). She had	spoken with the Nurse					
	Practitioner who ha	d been on call 7/1/24 and she					
	had not been made	aware of these lab results.					
		be sent out to the Emergency					
	Room (ER) for rena	al failure.					
	I -	ated 7/2/24 at 3:29 p.m.,					
		Practitioner had ordered to					
	send the resident to	the ER for abnormal labs.					

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

Event ID:

QF3L11

Facility ID: 000471

If continuation sheet Page 27 of 38

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	r í		NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLETED	
		155572	B. WI	ING	_	09/23/2024	
NAME OF B	ADOLUDED OD GUDDU IER			STREET A	ADDRESS, CITY, STATE, ZIP COD		_
NAME OF P	PROVIDER OR SUPPLIEF	C			N 600 E COUNTY LINE RD		
APERION	N CARE DEMOTTE			DEMOT	TE, IN 46310		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	,	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY	DATE	
	•	ated 7/2/24 at 3:30 p.m.,					
	resident to the ER.	een called to transport the					
	resident to the EK.						
	A Progress Note, dated 7/2/24 at 3:47 p.m.,						
	· ·	ergency Medical Services) was					
	at the facility and th	ne resident was going to the ER					
	for evaluation and t	reatment.					
	The hospital Admis	sion History and Physical,					
	•	ited the resident was admitted					
		ury. The chief complaint					
		al failure and electrolyte					
	abnormalities were	found on follow up labs.					
	Hyperkalemia (high	n potassium) and hyponatremia					
	(low sodium) were	mild and improved with IV					
	(intravenous) hydra	tion and the renal function					
	was also improving						
	During an interview	on 9/18/24 at 10:50 a.m., the					
	-	ident of Operations indicated					
	-	the situation. No further					
	information was pro	ovided.					
	Δ Facility Policy +	tled "Physician-Family					
		e in Condition," received as					
	-	The facility will inform the					
		th the resident's physician or					
		such as Nurse practitioner;					
	_	y the resident's legal					
		interested family member					
	-	A significant change in the					
		mental, or psychosocial status					
	[i.e. deterioration in						
	_	in either life-threatening					
		al complications]C. A need					
		gnificantly [i.e. a need to					
		ting form of treatment due to					
	adverse consequence	es, or to commence a new					
	form of treatment];	A need to alter treatment					

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

Event ID:

QF3L11 Facility ID: 000471

If continuation sheet Page 28 of 38

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155572		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 09/23/2024	
		100072	B. WI	_		09/23/	/2024
	ROVIDER OR SUPPLIER			10352 1	ADDRESS, CITY, STATE, ZIP COD N 600 E COUNTY LINE RD ITE, IN 46310		
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	(X5) COMPLETION
F 0880 SS=D Bldg. 00	significantly means treatment because o commence a new for problem" 3.1-49(f)(2) 483.80(a)(1)(2)(4) Infection Prevention Based on observation review, the facility equipment was disinfor 1 of 8 residents administration obset 1) Finding includes: During a medication at 11:12 a.m., LPN Resident 9's medical had to check the resigiving him his medipressure wrist cuff took it into the resident's right wrist The blood pressure removed the blood plood pressure cuff LPN then proceeded residents. The LPN was not of pressure cuff before residents.	a need to stop a form of of adverse consequencesor orm of treatment to deal with a	F 08	TAG	Tag number: F880 Infection Control I. What corrective action(s) wil accomplished for those reside found to have been affected by deficient practice; Resident 9 no adverse outcomes related the alleged deficient practice. II. How other residents having potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents have the potential to affected by the alleged deficie practice. LPN 1 educated on the proper procedure for disinfecting multi use equipment to include blood pressure cuffs III. What measures will be put place and what systemic chain will be made to ensure that the deficient practice does not recomponent to the policy "Cleaning & Sanitizing - Wheelchairs and Other Medical Equipment" to include cleaning multi use	Il be ints y the had to the inthe ing e into iges e ur; sing	11/01/2024
		indicated she normally would ssure cuff before and after			equipment IV. How the corrective action(s	s)	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>00</u>			COMPLETED	
		155572	B. WI	NG	_	09/23/	2024	
	PROVIDER OR SUPPLIER		<u> </u>	10352 I	ADDRESS, CITY, STATE, ZIP COD N 600 E COUNTY LINE RD TTE, IN 46310			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S DLAN OF CODDECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	using it on a resider	at and she did not.			will be monitored to ensure the	e		
					deficient practice will not recui	•		
		on 9/19/24 at 11:44 a.m., the			i.e., what quality assurance			
		dent of Operations indicated			program will be put into place;			
		e cleaned the blood pressure			DON/designee to do random			
	cuff prior to using it	t on the resident.			audits to ensure nursing staff	are		
	A maliary titled "Cla	soning & Conitiging			following proper disinfecting			
		eaning & Sanitizing - her Medical Equipment",			procedures. Audits will be	ν V Q		
		from the facility on 9/19/24,			completed on 3 nurses a weel weeks, then 1 nurse a week x			
		rices/equipment used for more			months.	7		
		all be cleaned between each			The results of these audits will	l be		
	resident"				reviewed in Quality Assurance			
					Meeting monthly for 6 months			
	3.1-18(b)				until an average of 90%			
					compliance or greater is achie	ved		
					x4 consecutive weeks. The Q	:A		
					Committee will identify any tre	nds		
					or patterns and make			
					recommendations to revise the	е		
					plan of correction as indicated			
					Date of compliance: 11/1/24			
F 9999								
Bldg. 00								
			F 99	999	Tag number: F9999		11/01/2024	
	3.1-18 Infection cor	ntrol program		. , ,	I. What corrective action(s) wil	l be	11/01/2027	
					accomplished for those reside			
	(h) All skin testing	for tuberculosis shall be done			found to have been affected b			
		method administered by			deficient practice; No resident	-		
	persons having docu	umentation of training from a			were affected by the alleged			
	department approve	d course of instruction in			deficient practice.			
	intradermal tubercu	lin skin testing, reading and			II. How other residents having	the		
	recording.				potential to be affected by the			
					same deficient practice will be			
	3.1-14 Personnel				identified and what corrective			
					action(s) will be taken; CNA 1	was		
	(t)(1) At the time of	employment, or within one (1)			given a 1st and 2nd step PPD	by		
	month prior to empl	loyment, and at least annually			date of compliance by a traine	d		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155572	B. W	NG		09/23/	/2024
		<u> </u>		CTDEET 4	ADDRESS CITY STATE ZIR COR		
NAME OF F	PROVIDER OR SUPPLIER	3			ADDRESS, CITY, STATE, ZIP COD		
ADEDIO	U CADE DEMOTTE				N 600 E COUNTY LINE RD		
APERIO	N CARE DEMOTTE	:		DEMOT	TTE, IN 46310		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	thereafter, employe	es and nonpaid personnel of			staff member. A full house au	dit	
	facilities she be screened for tuberculosis. For				was completed on all new hire	es in	
	health care workers who have not had a				the past 30 days to ensure the	∍y	
	documented negative	ve tuberculin skin test result			received their 1st and 2nd ste	р	
	during the precedin	g twelve (12) months, the			PPD and it was administered l	by a	
	baseline tuberculin	skin testing should employ the			trained staff member. Nurses	to be	
	two-step method. If	the first step is negative, a			trained on administering a PP	D by	
		be performed one (1) to three			date of compliance.		
	(3) weeks after the	first step. The frequency of			III. What measures will be put	into	
		lepend on the risk of infection			place and what systemic chan	iges	
	with tuberculosis.				will be made to ensure that the	е	
					deficient practice does not rec	ur;	
	This rule was not m	et as evidenced by:			DON/designee to train nurses	on	
					administering a PPD. HR dire	ector	
		view and interview, the facility			educated on monitoring		
		ff had received Mantoux			administration of 1st and 2nd	step	
	,	ulosis test) training by an			PPDs upon hire		
		or to administering the			IV. How the corrective action(s	s)	
		f 6 new employee records			will be monitored to ensure the	е	
		ee 7, RN 3, RN 4, RN 5, LPN 3,			deficient practice will not recui	٢	
		Director of Nursing) The			i.e., what quality assurance		
	1	o ensure a new employee had			program will be put into place;	HR	
		rculosis prior to working in			director/designee to complete	an	
	I -	6 new employee records			audit on all new hires to ensur	e	
	reviewed. (CNA 1)				they were given their 1st and 2	2nd	
					step PPDs by a trained staff		
	Findings include:				member.		
	<u> </u>						
		Employees 2, 3, 4, 5 and 6 were			The results of these audits will		
		4 at 12:50 p.m. The following			reviewed in Quality Assurance		
	Mantoux test were	completed:			Meeting monthly for 6 months	or	
	F 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	7/04 4 1			until an average of 90%		
		7/24 Administered and read by			compliance or greater is achie		
	Employee 7. 6/2/24 Administered and read by				x4 consecutive weeks. The Q		
	Employee 7.				Committee will identify any tre	nds	
	1. E1- 2. 5/0/	0/24 A durining to 11			or patterns and make	_	
	b. Employee 3: 5/28/24 Administered and read by				recommendations to revise the		
	KN 3. 6/17//24 Adm	iinistered and read by RN 4.			plan of correction as indicated		
	F 1 4 2 14	1/04 4 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1			Date of compliance: 11/1/24		
	c. Employee 4: 6/14	1/24 Administered and read by	1				

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

PRINTED: 11/13/2024 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155572		A. BUILDING 00 B. WING			COMPLETED 09/23/2024		
NAME OF P	ROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP COD		
APERION	CARE DEMOTTE				TE, IN 46310		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION]	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	d. Employee 5: 9/10 the Director of Nurse. Employee 6: 7/23	inistered and read by RN 5. 0/24 Administered and read by sing. 6/24 Administered and read by 8/10/24 Administered and read					
	Human Resource (F the above staff who	on 9/19/24 at 2:30 p.m., the HR) Director indicated none of administered or read the certified. She was unaware it					
	CNA 1 indicated sh facility on 8/20/24.	ew on 9/19/24 at 9:52 a.m., e had started working at the She had not yet received a ad not received one at her east a year.					
	CNA 1's Mantoux to review. It was not a	est was requested from HR for vailable.					
	HR Director indicat	on 9/19/24 at 10:30 a.m., the ed she did not have CNA 1's had meant to follow up with the but did not.					
	This citation relates	to Complaint IN00442992.					
R 0000							
Bldg. 00	Survey. This visit in State Licensure Sur	State Residential Licensure and a Recertification and vey and the Investigation of applaint IN00442992.	R 00	000			

State Form Event ID: QF3L11 Facility ID: 000471 If continuation sheet Page 32 of 38

STATEMEN	T 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	ETED
		155572	B. W	ING		09/23/	2024
				STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	ROVIDER OR SUPPLIER				N 600 E COUNTY LINE RD		
APERION	N CARE DEMOTTE				ΓΤΕ, IN 46310		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID			(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'		COMPLETION
TAG	· ·	LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	DATE
		2992- State deficiencies related					
	to the allegations are						
	_						
Survey dates: September 16, 17, 18, 19, 20 and 23,					ļ		
	2024.					ļ	
	Facility number: 00	0471					
	racinty number. 00	04/1					
	Residential Census:	5				ļ	
		ntial Findings are cited in					
	accordance with 410	0 IAC 16.2-5.					
	Ovality mayiayy a am	mloted on 0/20/24				ļ	
	Quality review com	pieted on 9/30/24.				ļ	
R 0214	410 IAC 16.2-5-2(a)					
	Evaluation - Defici	· ·					
Bldg. 00							
		riew and interview, the facility	R 0	214	Tag number: R214 Evaluation		10/11/2024
		ni-Annual Evaluations were			I. What corrective action(s) wil		
	-	very six (6) months for 2 of 7			accomplished for those reside		
	records reviewed. (I	Residents 1 and 6)			found to have been affected by	-	
	Findings include:				deficient practice; Resident 1 l a semi-annual evaluation	nad	
	rindings include.				completed on 9/23/24. Reside	nt 6	
	1. Resident 1's reco	ord was reviewed on 9/20/24 at			no longer resides in assisted	0	
		es included, but were not			living.	ļ	
		obstructive pulmonary disease			II. How other residents having	the	
	and hypertension.	1			potential to be affected by the		
	J F				same deficient practice will be		
	The last AL Function	onal Assessment was			identified and what corrective		
	completed on 12/13				action(s) will be taken; All		
	1				residents have the potential to	be	
	During an interview	on 9/23/24 at 9:07 a.m., the			affected by the alleged deficie		
	_	dicated the AL Functional			practice. A full house audit wa		
		eir Semi-Annual Evaluation			completed to ensure all reside		
		dditional assessments for the			had a semiannual assessment		
	resident.	deliveral acceptancia for the			completed per regulations.	•	
		rd was reviewed on 9/23/24 at			III. What measures will be put	into	
		s included, but were not limited			place and what systemic chan		
	7.51 a.m. Diagnoses	s meraded, but were not infined			Place and what systemic chair	yes	

State Form Event ID: QF3L11 Facility ID: 000471 If continuation sheet Page 33 of 38

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155572		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 09/23/2024	
		10352	N 600 E COUNTY LINE RD		
(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY	(X5) COMPLETION DATE	
to, bipolar disorder, and type 2 diabetes A Semi-Annual Eva 12/13/23. There were no other available for review During an interview Nurse Consultant in Evaluation was over	major depressive disorder, mellitus. cluation was completed on Semi-Annual Evaluations on 9/23/24 at 10:37 a.m., the dicated the Semi-Annual rdue and should have been		deficient practice does not reconstructed by seminary assessments. IV. How the corrective action will be monitored to ensure the deficient practice will not recursive, what quality assurance program will be put into place; SSD/designee to audit resider semiannual assessments to ensure they are being completed to the seminary and the seminary an	e eur; on s) e e e e e e e e e e e e e e e e e e	
failed to complete a 1 of 7 residents revi Finding includes: Record review for F 9/23/24 at 9:28 a.m.	Pre-Admission Evaluation for ewed. (Resident 5) Resident 5 was completed on Diagnoses included, but were	R 0215	accomplished for those reside found to have been affected b deficient practice; Resident 5 no adverse outcomes related the deficient practice. II. How other residents having	nts y the had to the	
	PROVIDER OR SUPPLIER N CARE DEMOTTE SUMMARY S (EACH DEFICIENT REGULATORY OR to, bipolar disorder, and type 2 diabetes A Semi-Annual Eva 12/13/23. There were no other available for review During an interview Nurse Consultant in Evaluation was over completed every 6 re substituting the substitution of t	PROVIDER OR SUPPLIER N CARE DEMOTTE SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION to, bipolar disorder, major depressive disorder, and type 2 diabetes mellitus. A Semi-Annual Evaluation was completed on 12/13/23. There were no other Semi-Annual Evaluations available for review. During an interview on 9/23/24 at 10:37 a.m., the Nurse Consultant indicated the Semi-Annual Evaluation was overdue and should have been completed every 6 months. 410 IAC 16.2-5-2(b) Evaluation - Deficiency Based on record review and interview, the facility failed to complete a Pre-Admission Evaluation for 1 of 7 residents reviewed. (Resident 5)	DENTIFICATION NUMBER 155572 STREET 10352 DEMO SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION to, bipolar disorder, major depressive disorder, and type 2 diabetes mellitus. A Semi-Annual Evaluation was completed on 12/13/23. There were no other Semi-Annual Evaluations available for review. During an interview on 9/23/24 at 10:37 a.m., the Nurse Consultant indicated the Semi-Annual Evaluation was overdue and should have been completed every 6 months. 410 IAC 16.2-5-2(b) Evaluation - Deficiency Based on record review and interview, the facility failed to complete a Pre-Admission Evaluation for 1 of 7 residents reviewed. (Resident 5) Finding includes: Record review for Resident 5 was completed on 9/23/24 at 9:28 a.m. Diagnoses included, but were not limited to, diabetes mellitus, hypertension,	PROVIDER OR SUPPLIER N CARE DEMOTTE SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR IS CONSTITUTION TO BE PRECEDED BY FULL A Semi-Annual Evaluation was completed on 12/13/23. There were no other Semi-Annual Evaluations available for review. During an interview on 9/23/24 at 10:37 a.m., the Nurse Consultant indicated the Semi-Annual Evaluation was overdue and should have been completed every 6 months. The results of these audits will reviewed in Quality Assurance Meeting monthly for 6 months until an average of 90% compliance or greater is achie at 2 consultive weeks. The C Committee will identify any tre or patterns and make recommendations to revise the plan of correction as indicated Date of compliance: 11/1/1/24 410 IAC 16.2-5-2(b) Evaluation - Deficiency Based on record review and interview, the facility failed to complete a Pre-Admission Evaluation for 1 of 7 residents reviewed. (Resident 5) Finding includes: Record review for Resident 5 was completed on 9/23/24 at 9:28 a.m. Diagnoses included, but were not limited to, diabetes mellitus, hypertension,	

State Form Event ID: QF3L11 Facility ID: 000471 If continuation sheet Page 34 of 38

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

PRINTED: 11/13/2024 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155572			A. BUIL B. WIN	DING	00	COMPL 09/23/	ETED
	ROVIDER OR SUPPLIER			10352 N	DDRESS, CITY, STATE, ZIP COD 600 E COUNTY LINE RD TE, IN 46310		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
R 0216	resident was admitted There was a lack of Pre-Admission Eval prior to the resident During an interview Administrator indicates from their Healthcan	documentation that a uation had been completed being admitted to the facility. on 9/23/24 at 10:35 a.m., the ated the resident transferred re side to the Assisted Living ion Evaluation was missed			identified and what corrective action(s) will be taken; Any resident admitted to assisted li has the potential to be affected the alleged deficient practice. III. What measures will be put place and what systemic change will be made to ensure that the deficient practice does not reconstructed a preadmission evaluation on any resident being evaluated for assisted living IV. How the corrective action(s will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; Administrator/designee will aud all possible admission to ensure preadmission assessment has been completed. Audits will be completed weekly x 3 months. The results of these audits will reviewed in Quality Assurance Meeting monthly for 6 months until an average of 90% compliance or greater is achief x4 consecutive weeks. The Quality Committee will identify any tree or patterns and make recommendations to revise the plan of correction as indicated. Date of compliance: 11/1/24	I by into ges iur; on ng) dit re a be or ved A nds	
Bldg. 00		iew and interview, the facility edication self-administration	R 021	16	Tag number: R216 I. What corrective action(s) will	be	11/01/2024

State Form Event ID: QF3L11 Facility ID: 000471 If continuation sheet Page 35 of 38

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	COMPLETED
		155572	B. W	ING _		09/23/2024
				STREET	ADDRESS, CITY, STATE, ZIP COD	
NAME OF	PROVIDER OR SUPPLIEF	t			N 600 E COUNTY LINE RD	
APFRI∩	N CARE DEMOTTE	:			TTE, IN 46310	
	· ·				T	Т
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	, and the second	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	-	TAG	DEFICIENCY	DATE
		apleted for 2 of 7 residents			accomplished for those reside	
	reviewed. (Resider	ats 2 and 6)			found to have been affected b	- I
F. C				deficient practice; Resident 6		
Findings include:				longer resides in assisted livin	g.	
	1 D:1 (2)				Resident 2 had a med	
		rd was reviewed on 9/20/24 at			self-administration assessmer	nt
		es included, but were not			completed on 10/15/24.	41
	_	lisorder, Alzheimer's disease,			II. How other residents having	
		The resident was admitted to			potential to be affected by the	
	the facility on 5/10/	ሃ ን.			same deficient practice will be	,
	The Santambar 202	4 Physician Order Summary			identified and what corrective	
	_	nt self-administered diclofenac			action(s) will be taken; All	, ho
		gel (pain relief gel), 2 grams to			residents have the potential to	
	left foot topically e			affected by the alleged deficient practice. A full house audit was		
	left foot topically e	very day and mgm.				
	The most recent Se	rvice Plan, dated 11/1/23,			completed to ensure any residuho who keeps meds at bedside h	
		to administer medications to			medication self-administration	
		did not self-administer any			assessment completed.	
	medications.	ara not son-administer any			III. What measures will be put	into
	medications.				place and what systemic char	
	There was a lack of	any self-administration of			will be made to ensure that the	-
		nent related to the diclofenac			deficient practice does not rec	
	sodium gel.				DON/designee will educate	· · · · · ·
					nursing staff on completing	
	During an interview	on 9/23/24 at 10:58 a.m., the			medication self-administration	
	Nurse Consultant in				assessments on any resident	
		of medication assessment was			keeps meds at bedside.	
		but staff should have assessed			IV. How the corrective action(s)
	every 6 months.				will be monitored to ensure the	•
					deficient practice will not recu	
					i.e., what quality assurance	
	2. Resident 6's reco	rd was reviewed on 9/23/24 at			program will be put into place;	
	9:31 a.m. Diagnose	s included, but were not limited			DON/designee will audit	
		ive pulmonary disease and			medication self-administration	
	type 2 diabetes mel	litus.			assessments to ensure they a	re
					completed as per regulations.	
	The most recent Se	rvice Plan, dated 4/26/24,			Audits will be completed week	dy x
	indicated the reside	nt was able to self-administer			3 months.	
	nasal spray, lotion,	and inhaler which he kept at			The results of these audits wil	l be

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRU			(X3) DATE SURVEY			
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING 00		00	COMPLETED			
		155572	B. W.	NG		09/23/	2024		
NAME OF PROVIDER OR SUPPLIER APERION CARE DEMOTTE				STREET ADDRESS, CITY, STATE, ZIP COD 10352 N 600 E COUNTY LINE RD DEMOTTE, IN 46310					
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	NEOVIDERIC N. AN OF CORRECTION		(X5)		
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION			PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION		
TAG				TAG	DEFICIENCY)		DATE		
	the bedside. The September 2024 Physician Order Summary indicated the resident was able to self administer the following medications: - Fluticasone propionate suspension (nasal spray) 50 micrograms/actuation 1 spray each nostril once daily - Ipratropium albuterol solution 0.5-2.5 3 milligram per 3 milliliter inhalation once every 12 hours - Biofreeze gel 4% (topical pain reliever), apply to bilateral hips twice daily There were no self-administration of medication assessments completed related to the medications. During an interview on 9/23/24 at 10:58 a.m., the Nurse Consultant indicated the self-administration of medication assessment should have been completed every 6 months.			reviewed in Quality Assuran Meeting monthly for 6 month until an average of 90% compliance or greater is ach x4 consecutive weeks. The Committee will identify any tor patterns and make recommendations to revise plan of correction as indicate Date of compliance: 11/1/24		or ved A nds			
R 0217	410 IAC 16.2-5-2(Evaluation - Defici								
Bldg. 00	failed to ensure Serrevised and updated (Residents 5 and 2) Findings include: 1. Record review fo 9/23/24 at 9:28 a.m. not limited to, diabed depression, and con resident was admitted. There was no document of the service of the	riew and interview, the facility vice Plans were completed, I for 2 of 7 residents reviewed. The Resident 5 was completed on an Diagnoses included, but were extended to the facility on 7/30/24. The resident 5 was completed on a Diagnoses included, but were extended to the facility on 7/30/24. The resident to indicate a Service objected after the resident	R 0.	217	Tag number: R217 I. What corrective action(s) will accomplished for those reside found to have been affected by deficient practice; Resident 5's service plan was completed or 10/25/24, resident 2's service was completed on 10/28/24 II. How other residents having potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents have the potential to affected by the alleged deficie	nts y the s n plan the	11/01/2024		

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

PRINTED: 11/13/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00			(X3) DATE SURVEY COMPLETED	
The TEXAL OF COMMENTAL		155572	B. WING			09/23/2024	
NAME OF PROVIDER OR SUPPLIER APERION CARE DEMOTTE			STREET ADDRESS, CITY, STATE, ZIP COD 10352 N 600 E COUNTY LINE RD DEMOTTE, IN 46310				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	тс	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG			DATE
	admitted to the faci	admitted to the facility.			practice.		
					III. What measures will be put	into	
	During an interview on 9/23/24 at 10:35 a.m., the				place and what systemic char	nges	
	Administrator indicated the resident transferred				will be made to ensure that the	e	
	from their Healthcare side to the Assisted Living				deficient practice does not rec	eur;	
	side. A Service Plan had not been completed on				SSD educated on completing		
	the resident.				service plans timely for reside		
	2. Resident 2's record was reviewed on 9/20/24 at				IV. How the corrective action(s)		
	1:31 p.m. Diagnoses included, but were not				will be monitored to ensure the		
	limited to, bipolar disorder, Alzheimer's disease,				deficient practice will not recur		
	and schizophrenia. The resident was admitted to				i.e., what quality assurance		
	the facility on 5/10/99.				program will be put into place;		
					SSD will audit service plans to		
	The most recent Service Plan, dated 11/1/23,				ensure they are completed tim		
	indicated the resident had a mental status				Audits will be completed week	dy x	
	diagnosis of schizophrenia and was seen by a				3 months.		
	Licensed Clinical Social Worker for talk therapy				The results of these audits wil		
	services.				reviewed in Quality Assurance		
					Meeting monthly for 6 months or		
	There was no documentation in the record				until an average of 90%		
	reflecting psychiatric services provided, including				compliance or greater is achieved		
	a Physician's Order for services.				x4 consecutive weeks. The C	•	
					Committee will identify any tre	ends	
	During an interview on 9/23/24 at 12:33 p.m., the				or patterns and make		
	Nurse Consultant indicated the Service Plan was				recommendations to revise the		
	outdated. The resident had never been seen by				plan of correction as indicated.		
		and it was believed to be			Date of compliance: 11/1/24		
	marked in error on	the Service Plan.					

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