STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155702	A. BUILDING 00 B. WING	09/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
APERION CARE PERU	1850 WEST MATADOR ST PERU, IN 46970

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00411463 and IN00412410. Complaint IN00411463 - No deficiencies related to the allegations are cited. Complaint IN00412410 - Federal/state deficiences related to the allegations are cited at F580, F622 and F690. Survey dates: September 25, 26, 27, 28 and 29, 2023 Facility number: 003130 Provider Number: 155702 AIM number: 200386750 Census Bed Type: SNF/NF: 77 Total: 77 Census Payor Type: Medicare: 2 Medicaid: 64 Other: 11 Total: 77 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed 10/7/2023.	F 0000	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	
F 0580 SS=D Bldg. 00	483.10(g)(14)(i)-(iv)(15) Notify of Changes (Injury/Decline/Room, etc.) §483.10(g)(14) Notification of Changes.			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Tammy Matthews	Administrator	10/26/2023

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

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	(i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15)			

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	Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). Based on record review and interview, the facility failed to notify the physician of significant weight losses, abnormal blood glucose levels and failed to notify the family of a hospitalization and change of condition in 3 of 3 residents reviewed for physician notification. (Resident 21, C & D) Findings include: 1. A record review was completed on, 9/28/2023 at 2:19 P.M. Resident 21's diagnoses included, but were not limited to obstructive uropathy, diabetes, dementia, arthritis, Parkinson's disease and malnutrition. An Admission MDS (Minimum Data Set) assessment, dated 6/9/2023, indicated Resident 21 required total assistance of 2 staff for bed mobility, transfers, bathing, and personal hygiene. Resident 21's weight history indicated on 6/23/2023 the weight was documented as 150.0. On 8/14/2023 Resident 21 was admitted to the hospital to have a leg amputation and returned on 8/25/2023. Resident 21's weights are as follows: A readmission weight was not obtained. On 8/28/23 the resident's weight was documented	F 0580	**F580** **The Facility is requesting paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** Resident #21's physician and family notified of weight loss, Resident #35 physician was notified blood glucose level out of range. Resident D family and physician has already been notified of the change of condition and hospitalization, as well as	10/26/2023

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	as 128.5. On 9/1/23 the resident's weight was documented as 136.5 showing a gain of 8 lbs. in 4 days. On 9/15/23 the resident's weight was documented as 129.5 showing a loss of 7 lbs. indicating a 5.13% loss in 15 days. On 9/28/23 the resident's weight was documented as 129.0. A current care plan, dated 8/30/2023, indicated the resident had an unplanned/unexpected weight loss related to poor food intake and a right leg below the knee amputation. Interventions included: Monitor and evaluate any weight loss. Determine percentage lost and follow facility protocol for weight loss. Monitor and record food intake at each meal A current care plan, dated 9/28/2023, indicated the resident had a nutritional problem or potential nutritional problem related to protein malnutrition, diabetes, dysphagia, poor oral intake at times. She was on a general puree diet with double portions with pudding thick liquids. Interventions included, but were not limited to, monitor/record/report to MD PRN (as needed) signs and symptoms of malnutrition/ significant weight loss: 3 lbs in 1 week, >5% in 1 month, >7.5 % in 3 months, and >10% in 6 months. The clinical record lacked the documentation to show the physician had been notified of the residents significant weight changes from 8/28/2023 to 9/15/2023. During an interview, on 9/28/33023 at 10:53 A.M., the Assistant Director of Nursing indicated there was no documentation of the physician being notified of the weight loss and should have been. 2. A record review of Resident 35 was completed		updated current contact information in residents chart. **2) How the facility identified other residents:** All residents have the potential to be affected by the alleged cited deficiency. Any resident who had a change of condition to include abnormal blood glucose, hospital transfer, and signification weight loss in the past 30 days were reviewed to ensure physician/family notifications were completed. **3) Measures put into place/ System changes:** Nursing staff was re-educated on Notification of changes, including but not limited to, ensuring physician and family notification of significant weight loss, blood glucose levels out of range, hospitalizations, and change of condition. DON/designee will review progress notes/orders to ensure physician/family notifications have been completed for any change of condition to include weight loss, abnormal blood glucose levels and hospital transfers. - **4) How the corrective actions will be monitored:** Audits will be completed 5 days a week x 4 weeks, 2x a week x 4	

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	on 9/27/2023 at 10:22 A.M. Diagnoses included, but were not limited to: diabetes mellitus type 2, history of cardiac arrest, and hepatitis C. An Annual Minimum Data Set (MDS) assessment, dated 8/8/2023, indicated Resident 35 had severe cognitive impairment and received insulin injections for seven days of the seven day look back period. A Physician's Order, dated 8/16/2023, indicated to monitor blood glucose fingerstick monitoring twice daily, and to call the physician if Resident 35's blood glucose was under 60 or above 400. A review of Resident 35's blood glucose results indicated a blood glucose of 425 on 9/14/2023, and 424 on 9/24/2023. During an interview on 9/28/2023 at 1:24 P.M., LPN 10 indicated if a blood glucose level was out of range from the provided scale the physician provided, then the physician should be called immediately. On 9/29/2023 at 9:43 A.M., the Director of Nursing indicated the doctor would be contacted when the blood glucose reaches 401 for Resident 35. She reviewed the Medication Administration Record, and indicated a checkmark was present indicating the blood glucose level was obtained, but she could not find a Physician Progress Note where the physician had been notified of the out-of-range blood glucose levels. 3. During an interview on 9/26/2023 at 9:43 A.M., the guardian for Resident D indicated she did not get notified of changes in treatments, or a recent hospitalization.		weeks, weekly x 4 weeks, then monthly x 3 months. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 100% compliance is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	

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	A record review was completed on 9/27/2023 at 8:40 A.M. Diagnoses included, but were not limited to: psychosis, history of traumatic brain injury, vascular dementia, anxiety disorder, and affective disorder. An Annual Minimum Data Set (MDS) assessment, dated 9/18/2023, indicated Resident D had severe cognitive impairment. A Nurse's Note, dated 6/16/2023 at 9:33 A.M., indicated Resident D came to the staff with a complaint of a headache, requesting treatment for the headache. This was "very unusual for this resident". Tylenol was administered, and complaints of the headache continued. The physician was notified of the unusualness of Resident D to come to staff with complaints of a headache, and requesting treatment. Resident D's current Tylenol order was updated to every six hours. On 6/16/2023 at 12:03 P.M., Resident D was observed by staff in his room with tremors to bilateral hands, and continued to complain of a headache. The physician was updated again on Resident D's condition. On 6/16/2023 at 12:10 P.M., new orders were received for stat labs, and the POA was called, and a message left to return call to facility. On 6/17/2023 at 12:09 P.M., Resident D had a temperature of 101.3 Fahrenheit after he received Tylenol. He had diminished lung sounds and wheezing noted. A new order was received from the physician for Invanz (an antibiotic) one gram intramuscularly daily for five days. On 6/18/2023 at 10:45 P.M., Resident D had an			

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	unwitnessed fall in his room. He was bedside, wrapped in a blanket, confused, sweaty, and breathing hard. The physician was notified, and an order was obtained to send to the emergency room. The note indicated staff attempted to call the guardian, but whomever answered indicated it was a wrong number. No further attempts were made to call the guardian or the secondary contact in the medical record. Resident D was discharged to the hospital on 6/18/2023, and returned on 6/22/2023. During an interview on 9/28/2023 1:21 P.M., LPN 10 indicated all new physician orders should be communicated with the Power of Attorney/Guardian of the resident. She indicated if the first contact listed cannot be reached, she would call the next contact. On 9/29/2023 at 9:53 A.M., the Director of Nursing (DON), indicated the Power of Attorney/Guardian should be notified of all new orders and changes of condition, the nursing staff should have tried to contact the guardian again. On 9/28/2023 at 1:20 P.M., the Director of Nursing provided the policy titled, "Weights", dated 10/17/2019, and indicated the policy was the one currently used by the facility. The policy indicated" ...3. Re-weight should be obtained if there is a difference of 5# or greater (loss or gain) since previous recorded weight. 6. Undesired or anticipated weight gains/loss of 5% in 30 days, 7.5 % in three months, or 10% in six months shall be reported to the physician, Dietician and/or Dietary Manager as appropriate ...." On 9/29/2023 at 9:55 A.M., a policy titled,			

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	"Physician-Family Notification-Change in Condition", was provided by the Regional Nurse Consultant. The policy indicated, " ...To ensure that medical care problems are communicated to the attending physician or authorized designee and family/responsible party in a timely, efficient, and effective manner ...The facility will inform the resident; consult with the resident's physician or authorized designee such as Nurse Practitioner, and if known, notify the resident's legal representative or an interested family member when there is:..(B) A significant change in the resident's physical, mental, or psychosocial status ...(C) A need to alter treatment significantly ...A Need to alter treatment "significantly" means a need to stop a form of treatment because of adverse consequences, or commence a new form of treatment to deal with a problem ...(D) A decision to transfer or discharge the resident from the facility ...." This Federal tag relates to complaint IN00412410. 3.1-5(a)(3) 3.1-5(a)(4)			
F 0622 SS=D Bldg. 00	483.15(c)(1)(i)(ii)(2)(i)-(iii) Transfer and Discharge Requirements §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs			

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	the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose. §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider.			

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	(i) Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c)(1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care.			
	Based on record review and interview, the facility failed to ensure accurate clinical information was provided to the hospital for a hospital transfer, failed to obtain an order to transfer a resident to the hospital causing an unnecessary emergency room visit, and failed to obtain a physicians order	F 0622	**F622** **The facility requests paper compliance for this citation.** *This Plan of Correction is the*	10/26/2023

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	to discharge to the hospital for 3 of 3 residents reviewed for hospitalization. (Residents 21) Finding includes: 1. A record review was completed on 9/28/2023 at 2:19 P.M. Resident 21's diagnoses included, but were not limited to anemia, dysphagia (difficulty in swallowing), diabetes, dementia, arthritis, and Parkinson's disease. An Admission MDS (Minimum Data Set) Assessment, dated 6/29/2023, indicated the resident required extensive assist of 2 staff for bed mobility, transfers, dressing, eating and toilet use, and did not ambulate. Had a surgical wound, and 1 stage 2, and 1 stage 3 pressure ulcers. Treatment orders included: clease the area to the right hip with wound wash. Pat dry, and pack wound with 1/2 strength Dakin's soaked gauze and cover with dry border dressing once daily and PRN (as needed) for soilage and dislodgment. Current Physician orders, included pureed texture, pudding consistency diet. Allergies included: Cefepime, Morphine and ACE inhibitors. A Skin Condition Report sheet, dated 8/2/2023 indicated Resident 21 had a surgical wound to the right foot related to amputation of the right toes. Sutures remain. Moderate drainage noted. Resident currently started on antibiotic therapy. Resident has a history of chronic osteomyelitis (bone infection). A Progress Note, dated 8/14/2023, indicated the Physician had seen the resident and indicated the resident would be sent to the hospital on 8/15/2023 for direct admit.		*center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** Resident 21 had no adverse reactions related the alleged cited deficiency. **2) How the facility identified other residents:** All residents have the potential to be affected by the alleged cited practice. Moving forward, any resident transferred to the hospital will have a physician's order, and appropriate clinical information provided to the hospital. **3) Measures put into place/ System changes:** Social Service Director was educated on scope of practice related to transfer paperwork. Nursing staff educated on proper procedure for hospital transfers, to	

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	A Nursing Home to Hospital Transfer Form, dated 8/15/2023, indicated under the Diet section the question of trouble swallowing was checked No. Special consistency (thickened liquids, crushed med's etc. was check No. The section for Skin/Wound Care concerning pressure ulcers the documenting was checked n/a. The Usual Functional Status: the documentation was for Ambulated only with human assistance. Allergies indicated Cefepime only. For the Risk Alerts the was no documentation for pressure ulcers. The form completed by was signed by the Social Service staff. During an interview, on 9/28/2023 at 3:39 P.M., the Director of Nursing indicted the form was not accurate. During an interview, on 9/28/2023 at 4:18 P.M., the Social Service staff indicated she either help a nurse because she was new, and indicated "obviously I did it cause it has my name on it". The Social Service staff indicated that some of the information she did not know, and the information was inaccurate. On 9/29/2023 at 9:24 A.M., the Director of Nursing provided the policy titled, "Discharge/Transfer of Resident", undated and indicated the policy was the one currently used by the facility. The policy indicated"...7. Complete Transfer Form Accurately and completely including vital signs. Rationale/Amplification: Ensure that resident's current physical and psycho/social assessment, medications and current treatment is completely described and available to the receiving facility upon transfer...." This Federal tag relates to complaint IN00412410.		include physician order and sending clinical information. DON/designee will review hospital transfers to ensure an order was obtained and accurate clinical information was provided to the hospital. **4) How the corrective actions will be monitored:** Audits will be completed 5x a week for 4 weeks, 2x a week for 4 weeks, weekly x 4 weeks, then monthly x 3 months. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 100% compliance is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	3.1-12(a)(3)			
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on observation, record review, and interview the facility failed to provide personal hygiene to a resident unable to complete per self for 1 of 5 residents reviewed for activities of daily living. (Resident 21). Finding includes: During an observation, on 9/25/2023 at 1:55 P.M., Resident 21 was observed in his bed with contracted hands, dirty nails to both hands and unshaved with a large growth of whiskers. During an observation, on 9/26/2023 at 9:28 A.M., Resident 21 was observed unshaven with a large growth of whiskers. During an observation, on 9/27/2023 at 2:23 P.M., Resident 21 was observed unshaven with a large growth of whiskers. During an observation, on 9/28/2023 at 1:45 P.M., Resident 21 was observed unshaven with a large growth of whiskers. During an observation ,on 9/29/2023 at 9:30 A.M., Resident 21 was observed unshaven with a large growth of whiskers. A record review was completed on, 9/28/2023 at 2:19 P.M. Resident 21's diagnoses included, but	F 0677	**F677** **The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** Residents 21 was offered and provided grooming of facial hair and nail care. **2) How the facility identified other residents:** All residents have the potential to	10/26/2023

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	155702	A. BUILDING 00 B. WING	09/29/2023

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	were not limited to obstructive uropathy, diabetes, dementia, arthritis, Parkinson's disease and malnutrition. Required total assist of 2 staff for bed mobility, transfers, bathing, and personal hygiene. A current care plan, dated 9/26/2023, indicated the resident had an ADL (activities of daily living) self-care performance deficit. Required assist with mobility and ADLs including bed mobility, toileting, eating, and transferring related to Parkinson's disease, arthritis and dementia. Total care for all ADLs. Interventions included, but were not limited to: Bathing/Showering: Check nail length and trim and clean on bath day and as necessary. Report any changes to the nurse. Provide sponge bath when a full bath or shower cannot be tolerated. The resident requires total assist. Personal Hygiene/Oral Care: The resident requires total assist. Resident 21's shower documentation indicated the resident had received showers on the following dates: 9/4, 9/7. 9/14, 9/18, and 9/22. Bed baths were received on 8/31, 9/5, 9/11, 9/26 and 9/29. During an interview, on 9/29/2923 at 9:39 A.M., CNA 7 indicated the resident had not been shaved and should have been. On 9/29/2023 at 11:09 A.M., the Assistant Director of Nursing provided the policy titled, "Bathing-Shower and Tub Bath", dated 1/31/2018, and indicated the policy was the one currently being used. The policy indicated"...To ensure resident's cleanliness to maintain proper hygiene and dignity. A shower, tub bath or bed/sponge bath will be offered according to resident's preference two times per week or according to the resident's preferred frequency and as needed or		be affected by the alleged cited practice. A full house audit was completed to ensure all residents nails were clean and trimmed and facial hair was groomed. **3) Measures put into place/ System changes:** Nursing staff was educated on ADL care to include grooming of facial hair and nail care. DON/designee will conduct rounds to ensure residents nails are clean and trimmed and facial hair is groomed. **4) How the corrective actions will be monitored:** Audits will be completed on 5 residents a week x 8 weeks, then 5 residents a month x 4 months. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	

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	requested...." A policy was requested for providing personal hygiene, on 9/29/2023 at 1:49 P.M., the Director of Nursing indicated they did not have a policy on personal hygiene. 3.1-38(a)(3)			
F 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.			

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	§483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. Based on record review and interview, the facility failed to provide education to the nursing staff on care of nephrostomy tubes for 1 of 26 residents reviewed. (Resident C) Finding includes: A record Review of Resident C was completed on 9/25/2023 at 11:28 P.M. Diagnoses included, but were not limited to: traumatic brain injury, tracheostomy, PEG tube, aphasia, a stage 3 and 4 decubitus ulcer, and quadriplegia. A Nurse's Note, dated 7/22/2023 at 12:06 P.M., indicated Resident C had recently readmitted to the facility with bilateral nephrostomy tubes. The nephrostomy tubes were leaking approximately ninety percent of the urine excreted onto the bed and Resident C. On 7/22/2023 at 12:10 P.M. at 12:10 P.M., a Nurse's Note indicated a decision was made to send Resident C to the hospital based on barely any urine drained properly through the nephrostomy tubes. A Physician's Order could not be located in the medical record, nor documentation of the physician being updated on the resident's condition. An Emergency Documentation, dated 7/22/2023 at 6:55 P.M., indicated, " ...Bilat [Bilateral]	F 0690	**F690** **The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** Resident D no longer resides in the facility. **2) How the facility identified other residents:** All residents have the potential to be affected by the alleged cited	10/26/2023

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	nephrostomy tubes aspirated sediment but did not flush. Noted stopcock in place on 'lock' to bilat nephrostomy tubes. Stopcock was rotated open to both nephrostomy tubes. There was immediate return of yellow urine. Leg bags were changed bilaterally. Urine continued to flow freely from bilat tubes ...Urine output was approx [approximately] 550 mL [milliliters] from R [right] nephrostomy tube. Urine output was 250 mL from L [left] nephrostomy tube ...." During an interview on 9/29/2023 at 10:49 A.M. LPN 9 indicated when caring for nephrostomy tubes the main task was to keep the tubes flushed. He indicated the procedure required the nurse to turn the stopcock to the off position, flush the tubes, and open the stopcock. He indicated he had not received any training on nephrostomy tubes at the facility, but the discharging hospital provided instruction for care. On 9/29/2023 at 1:33 P.M., the Director of Nursing (DON) indicated staff training was not performed on nephrostomy tubes, and the resident came from the hospital with instructions. She indicated the nurse should have tried to look at the valves (stopcock) or call someone if she didn't understand how to provide care for the nephrostomy tubes. The DON indicated the nurse was a newer nurse, and may not have known how the nephrostomy tubes work. On 9/29/2023 at 3:10 P.M., the DON indicated LPN 8's job specific orientation could not be found in the employee's file. LPN 8 was hired at the facility on 4/2/2023. A policy titled, "Employee Education", was provided by the Unit Manager on 9/29/2023 at 2:53 P.M. The policy indicated, " ...The facility		practice. LPN 8 was educated on how to care for nephrostomy tubes. **3) Measures put into place/ System changes:** DON/designee will provide education and skills training on any resident with a new medical apparatus. A full house audit was completed to ensure staff was educated on any in house medical apparatus. DON/designee will audit new orders in daily in clinical meeting to ensure any new medical apparatus has the appropriate training provided to staff. **4) How the corrective actions will be monitored:** Audits will be completed 5 days a week x 4 weeks, 2x a week x 4 weeks, weekly x 4 weeks, then monthly x 3 months. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 100% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	

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	shall provide a Staff Education Plan in accordance with State and Federal regulations ...7. The facility will ensure that nursing staff are able to demonstrate competency in skills and techniques necessary to care residents" needs, as identified through resident assessments, and described in the plan of care ...." This Federal tag relates to complaint IN00412410.			
F 0692 SS=D Bldg. 00	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. Based on observation, record review and interview, the facility failed to provide water at the bed side for 1 of 2 residents reviewed for hydration. (Resident 20) Findings include:	F 0692	**F692** **The facility requests paper compliance for this citation.** *This Plan of Correction is the*	10/26/2023

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	During an observation, on 9/25/2023 at 2:03 P.M., no water container was noted on the bedside table. A record review was completed on, 9/27/2023 at 9:01 A.M. Resident 20's diagnoses included, but were not limited to: Cerebral palsy, dementia and osteoarthritis. A Quarterly MDS (Minimum Data Set) Assessment, dated 8/25/2023, indicated the resident had severe cognitive function. Required total assistance of 2 staff for bed mobility, transfers, and toilet use, and extensive assistance for dressing and 1 staff for eating. Resident 20's diet order was a regular texture and thin liquids and assist with all meals. A current care plan, dated 9/25/2023, indicated the resident was on a regular diet with thin liquids, ice cream at lunch and dinner, snacks four times a day. Interventions: encourage resident to be up for all meals. Monitor for signs/ symptoms of aspiration. Position for eating and drinking safely. Provide diet as ordered. Uses cup with straw. A current care plan, dated 7/28/2023, indicated the resident had an ADL self-care performance and functional mobility deficit with a risk of decline and require assist with ADLs and mobility including bed mobility, toileting, transfer and eating related to diagnoses's of Cerebral palsy, dementia, chronic pain, osteoarthritis, dysphagia, general weakness, blindness. Interventions included: EATING: The resident requires Physical Assist; resident is able to feed self some items such as a cookie or sandwich once she is assisted with holding the item in her hand, however		*center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** Residents 20 was offered and provided water at bedside. **2) How the facility identified other residents:** All residents have the potential to be affected by the alleged deficient practice The facility completed an audit to identify any other residents in need of water at bedside. No other concerns were noted. **3) Measures put into place/ System changes:** Staff educated on the policy “Water Pass/Hydration” to include offering fresh water 3x a day. DON/designee to conduct room audits to ensure residents have water at bedside	

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	resident requires total assist with all fluid intake and all food items requiring utensils. A current care plan, dated 4/17/2023, indicated Resident 20 was at risk for dehydration related to: Cognitive loss/may not recognize thirst, impaired mobility, impaired cognitive status, dysphagia, history of IV fluids for hydration, poor nutritional intake at times. Interventions included: Check skin turgor as indicated. Evaluate diet, refer to Dietician as needed. Observe for and report to nurse/physician: Dry mucus membranes, Confusion, Muscle weakness, Constipation, Sunken eyes, Dizziness, Irritability, Fever, Pneumonia, disorientation, Urinary tract infection, Tachycardia, Weight loss, Dry and poor skin elasticity, Less urine output, Increased heart rate, Low blood pressure (hypotension) or Increased infection occurrence. Obtain vital signs as ordered and report any irregularities. Offer extra fluids at med pass as ordered; see MAR (Medication Administration Record)/TAR (Treatment Administration Record). During an observation on 9/27/2023 at 9:22 A.M., Resident 20 had no water available at the bed side. During an interview, on 9/27/2023 at 9:43 A.M., the Director of Nursing indicted there should be water at the bedside and there was not. On 9/28/2023 the Corporate Nurse provided the policy titled," Water Pass-Hydration", dated 11/28/2012, and indicated the policy was the one currently used by the facility. The policy indicated..." Fresh cold ice waster will be provided to each resident a minimum of three times each day, unless contraindicated...." 3.1-46		**4) How the corrective actions will be monitored:** Audits will be completed on 10 rooms a week x 3 months, then 10 rooms a month x 3 months. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 95% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	

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F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation, interview and record review, the facility failed to ensure an insulin cart and a treatment cart were kept locked when unattended during 2 of 2 random observations. (100 and 200 Halls) Findings include: 1. During a random observation, on 9/27/2023 at 10:59 A.M., the insulin cart on the long hall was unlocked.	F 0761	**F761** **The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of*	10/26/2023

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	During an interview, on 9/27/2023 at 11:00 A.M., LPN 8 indicated the cart should not be unlocked. 2. During a random observation, on 9/28/2023 at 11:25 A.M., the treatment cart on 100 hall was unlocked. QMA 5 walked by the cart and locked it. During an interview, on 9/28/2023 at 11:26 A.M. QMA 5 indicated the cart should not be unlocked. On 9/28/2023 at 5:20 P.M., the Corporate Nurse provided the policy titled,"Medication Storage", dated 7/2/2019 and indicated the policy was the one currently used by the facility. The policy indicated"... 3. Facility should ensured that all medications and biological's, including treatment items, are securely stored in a locked cabinet/cart or locked medication room that is inaccessible by residents and visitors...." 3.1-25(m)		*this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** All medication / treatment carts were locked. **2) How the facility identified other residents:** All residents have the potential to be affected by the alleged deficient practice. The facility completed an audit to identify any medication/treatment carts that were unlocked and left unattended. No other concerns were noted. **3) Measures put into place/ System changes:** Licensed nurses and QMA's will be educated on the policy "Medication Storage" to include securing/locking medication and treatment carts. DON/designee will monitor ~~for~~ medication and treatment carts to ensure they are locked/secured	

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			when not in visual sight. **4) How the corrective actions will be monitored:** Audits will be completed 5 days a week x 4 weeks, 2x a week x 4 weeks, weekly x 4 weeks, then monthly x 3 months. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	
F 0812 SS=E Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the			

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	facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation, interview and record review, the facility failed to ensure expired liquids and spices were not in use, failed to ensure the pantry and activity refrigerators were clean and without undated, unnamed foods, in 1 of 1 kitchens and 2 of 2 pantries observed. (Main kitchen, nourishment and activity cafe' pantry) Findings include: 1. During the initial tour of the main kitchen on 9/25/2023 at 9:45 A.M., with the Dietary Manager, the following items were observed: - In the walk in cooler there was 2 containers with small cartons of milk that were expired. There were 8 cartons with the expiration date of 9/18/23, 10 cartons with the expiration date of 9/19/23 and 50 cartons with the expiration date of 9/23/2023. - In the walk in freezer, a large build of ice was observed hanging down on the right side of the condenser. During an interview, on 9/25/2023 at 9:50 A.M., the Dietary Manager indicated the milk should have been pulled and the ice build up should not be there. 2. During a followup observation of the kitchen, on 9/28/2023 at 1:06 P.M., the following was observed: - An opened (6/14/2021) container of the Ginger spice with a used by date of 12/24/2022. A	F 0812	**F812** **The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** No residents were identified as affected by the alleged deficient practice. **2) How the facility identified other residents:** All residents have the potential to be affected by the alleged deficient practice. **3) Measures put into place/**	10/26/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155702	A. BUILDING 00 B. WING	09/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
APERION CARE PERU	1850 WEST MATADOR ST PERU, IN 46970

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	container of ground nutmeg with an opened date of 11/2/2022 and a used by date of 5/2/2023. During an interview, on 9/28/2023 at 1:08 P.M., the Dietary Manager indicted the spices should have been thrown away. 3. During an observation of the nourishment pantry, on 9/28/2023 at 2:14 P.M.,with the Dietary Manager, the following were observed: - In a refrigerator freezer section there was a bag of pizza pieces with no resident identifiers. An opened bottle of water with no name, and 2 broken crisper drawers with visible dirt underneath them. During an interview, on 9/28/2023 at 2:16 P.M., the Dietary Manager indicated the food items should have had a name on it, the water bottle should have a name on it, and the refrigerator should have been cleaned. 4. During an observation of the cafe' pantry, on 9/28/2023 at 2:20 P.M., with Activity staff 12 the following was observed: -In the freezer there were long frozen pop cycles singles and 2 bags with chunks of ice on them, 2 opened containers of whipped topping with no date opened and ice crystals in the middle of the topping. A microwave cheese pizza with no name. During an interview, on 9/28/2023 at 2:23 P.M., Activity Staff 12 indicated the food items should have had a date opened on them and the ice was due to the fridge not working properly. She indicated the facility was looking to get a new one. On 9/26/2023 at 1:30 P.M., the Director of Nursing		**System changes:** Dietary Manager/dietary staff educated on the policy “Labeling and Dating Foods” to include disposing of expired items, cleaning of refrigerators, labeling and dating foods, and reporting any concerns to maintenance. The Dietary Manager/designee will perform an audit of all food storage areas as well as refrigerators/freezers to determine accurate dating, labeling, and expiration dates of all food products, along with appropriate sanitation. Any issues identified will be brought to the attention of the Dietary Manager, Executive Director, and any other applicable staff for immediate re-education. **4) How the corrective actions will be monitored:** Audits will be completed 5x a week x 4 weeks, 2x a weekly x 4 weeks, then monthly x 3 months. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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	provided the policy titled,"Labeling and Dating Foods (Date Marking), dated 2020, and indicated the policy was the one currently used by the facility. The policy indicated"... 2. Date marking for refrigerated storage food items. Once a case is opened, the individual, refrigerated food items are dated with the dated the item was received into the facility and placed in/on the proper storage location utilizing the"first in- first out" method of rotation. Once opened, all ready to eat, potential hazardous food will be re-dated with a use by date according to current safe food storage guidelines or by the manufactures expiration date. 3. Date marking for freezer storage food items... Frozen food packages removed from the case will be dated with the date the item was received into the facility will be stored using the "first in- first out" method of rotation...." 3.1-21(i)(3)			