12/07/2023

	EPARTMENT OF HEALTH AND HUMAN SERVICES ENTERS FOR MEDICARE & MEDICAID SERVICES							
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY			
AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155702		A. BUILDING B. WING		COMPLETED 10/31/2023				
	PROVIDER OR SUPPLII	ER	1850 W	STREET ADDRESS, CITY, STATE, ZIP COD 1850 WEST MATADOR ST PERU, IN 46970				
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE ENCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	IATE	(X5) COMPLETION DATE		
E 0000	REGULATORT	OK ESC IDENTIFY TING INFORMATION	TAG			DATE		
Bldg	conducted by the accordance with 4 Survey Date: 10/2 Facility Number: Provider Number: AIM Number: 20	31/23 003130 155702 00386750	E 0000					
	Care Peru was fou Emergency Prepa Medicare and Me and Suppliers, 42	y Preparedness survey, Aperion and not in compliance with redness Requirements for dicaid Participating Providers CFR 483.73. The facility has a I had a census of 83 at the time						
	Quality Review co	ompleted on 11/06/23						
	The requirements Not Met as evider	of 42 CFR, Subpart 483.73 are need by:						
E 0039 SS=F		16.54(d)(2), 418.113(d)(2), 82.15(d)(2), 483.475(d)(2).						

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

*[For ASCs at §416.54, CORFs at §485.68, OPO, "Organizations" under §485.727,

483.73(d)(2), 484.102(d)(2), 485.625(d)(2), 485.68(d)(2), 485.727(d)(2), 485.920(d)(2), 486.360(d)(2), 491.12(d)(2), 494.62(d)(2)

§416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)

EP Testing Requirements

(2), §491.12(d)(2), §494.62(d)(2).

Bldg. --

TITLE (X6) DATE

Administrator 12/04/2023 **Tammy Matthews**

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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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155702		(X2) MULTIPLE CO A. BUILDING B. WING	INSTRUCTION	(X3) DAT	(X3) DATE SURVEY COMPLETED 10/31/2023	
	PROVIDER OR SUPPLIEI	R	1850 W	ADDRESS, CITY, STATE, ZIP COI EST MATADOR ST IN 46970)	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP		(X5) COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	ROPRIATE	DATE
	CMHCs at §485.9	020, RHCs/FQHCs at RD Facilities at §494.62]:				
	exercises to test t	facility] must conduct the emergency plan sility] must do all of the				
	community-based (A) When a community accessible, confunctional exercis (B) If the [faction natural or man-materization of the exempt from exempt from exempt from exempt from exempt is exempt from exempt functional exercis actual event. (ii) Conduct an accevery 2 years, op or functional exercis	full-scale exercise that is a levery 2 years; or munity-based exercise is onduct a facility-based e every 2 years; or ility] experiences an actual ade emergency that requires emergency plan, the [facility] agaging in its next required a or individual, facility-based e following the onset of the liditional exercise at least posite the year the full-scale cise under paragraph (d)(2)				
	include, but is not (A) A second full-community-based functional exercis (B) A mock disast (C) A tabletop exeled by a facilitator discussion using clinically-relevant set of problem stamessages, or preto challenge an el (iii) Analyze the [fmaintain docume	ter drill; or ercise or workshop that is and includes a group a narrated, emergency scenario, and a atements, directed pared questions designed				

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the [facility's] emergency plan, as needed.

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	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING		COMPLETED	
		155702	B. WING		10/31/2023	
NAME OF I	PROVIDER OR SUPPLIEF			ADDRESS, CITY, STATE, ZIP COD		
٨٥٥٥١٥١	N CARE REPLI			VEST MATADOR ST		
APERIO	N CARE PERU		PERU,	IN 46970		
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX		ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI		
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
	*[For Hospices at	/18 113/d\·1				
		spices that provide care in				
	the patient's home. The hospice must conduct exercises to test the emergency					
		ally. The hospice must do				
	the following:					
	(i) Participate in a full-scale exercise that is					
	community based every 2 years; or					
		nunity based exercise is not				
	' '	ıct an individual facility				
	based functional e	exercise every 2 years; or				
	(B) If the hospice	experiences a natural or				
	man-made emergency that requires activation					
	of the emergency	plan, the hospital is				
	exempt from enga	aging in its next required full				
	scale community-	based exercise or individual				
		ctional exercise following the				
	onset of the emer					
	' '	dditional exercise every 2				
		e year the full-scale or				
		e under paragraph (d)(2)(i)				
		conducted, that may				
		limited to the following:				
	, ,	scale exercise that is				
		or a facility based				
	functional exercise					
	(B) A mock disas					
	. ,	ercise or workshop that is and includes a group				
	discussion using a	- ·				
		emergency scenario, and a				
	set of problem sta					
		pared questions designed				
	to challenge an er					
	2.2.23.193 4.11 01					
	(3) Testing for hos	spices that provide inpatient				
	· ,	hospice must conduct				
	-	he emergency plan twice				
		spice must do the following:				

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CENTERS FOR MEDICARE & MEDICAID SERVICES						OM	IB NO. 0938-039
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	<u></u>	COMPLETED	
		155702	B. WING 10/31/2023				/2023
							
NAME OF	PROVIDER OR SUPPLIEI	R			ADDRESS, CITY, STATE, ZIP COD		
ABEDIO	N OADE DEDII				EST MATADOR ST		
APERIO	N CARE PERU			PERU,	IN 46970		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	ī	(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI	E	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	VIATE	DATE
	(i) Participate in a	an annual full-scale exercise					
	that is community						
		nunity-based exercise is not					
	, ,	ict an annual individual					
	facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required						
	full-scale community based or facility-based						
	functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise						
	1 ' '	but is not limited to the					
	following:						
	•	-scale exercise that is					
	, ,	l or a facility based					
	functional exercis						
	(B) A mock disas						
	, ,	ercise or workshop led by a					
		udes a group discussion					
		clinically-relevant					
	1	ario, and a set of problem					
		ted messages, or prepared					
		ed to challenge an					
	emergency plan.	ou commongo um					
		nospice's response to and					
		ntation of all drills, tabletop					
		nergency events and revise					
		ergency plan, as needed.					
	and noopide 5 ciric	organis, as needed.					
	*[For PRFTs at 8/	141.184(d), Hospitals at					
	§482.15(d), CAH						
	- ' '	PRTF, Hospital, CAH] must					
		s to test the emergency					
	1 '	ar. The [PRTF, Hospital,					
	CAH] must do the	e ioliowing:					İ

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(i) Participate in an annual full-scale exercise

that is community-based; or

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING COMPLETE			ETED	
		155702	B. WING			10/31/	/2023
			STR	EET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	8			EST MATADOR ST		
APERION	N CARE PERU				IN 46970		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	I			(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREF	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	· ·	R LSC IDENTIFYING INFORMATION	TAG		CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
		unity-based exercise is not					
	1 ' '	ct an annual individual,					
		tional exercise; or					
	1	Hospital, CAH] experiences					
		or man-made emergency					
	that requires activ	ation of the emergency					
	plan, the [facility] i	s exempt from engaging in					
	its next required for	ull-scale community based					
	or individual, facili	ty-based functional exercise					
	following the onse	t of the emergency event.					
	(ii) Conduct a	an [additional] annual					
	exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is						
	community-based						
	1	ctional exercise; or					
	, ,	ck disaster drill; or					
		exercise or workshop that					
	1	or and includes a group					
	discussion, using						
	I -	emergency scenario, and a					
	set of problem sta	pared questions designed					
	to challenge an er						
	_	ne [facility's] response to					
	. , , .	umentation of all drills,					
		s, and emergency events					
	I	cility's] emergency plan, as					
	needed.	, of one going plan, as					
	*[For PACE at §46	60.84(d):]					
	(2) Testing. The P	ACE organization must					
	conduct exercises	to test the emergency					
	plan at least annu	ally. The PACE					
	organization must	_					
		n annual full-scale exercise					
	that is community						
	1 ' '	unity-based exercise is not					
		ct an annual individual,					
	facility-based fund	tional exercise; or					

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Event ID:

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, ´		X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING COMPLETED		
		155702	B. WING		10/31/2023
NAME OF T	DROWIDED OF CURPLUS		STREET	ADDRESS, CITY, STATE, ZIP COD	
NAME OF F	PROVIDER OR SUPPLIEF	C	1850 W	VEST MATADOR ST	
APERIO	N CARE PERU		PERU,	IN 46970	
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	
TAG	i	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY	DATE
	' '	xperiences an actual natural			
		ergency that requires			
		mergency plan, the PACE			
	is exempt from engaging in its next required full-scale community based or individual,				
		-			
	onset of the emer	ctional exercise following the			
	· ·				
	, ,	n additional exercise every the year the full-scale or			
		e under paragraph (d)(2)(i)			
		conducted that may include,			
	but is not limited to	•			
		scale exercise that is			
	community-based or individual, a facility				
	based functional e				
	(B) A mock disas				
	` '	ercise or workshop that is			
		and includes a group			
	discussion, using				
	_	emergency scenario, and a			
	set of problem sta				
	-	pared questions designed			
	to challenge an er	· · · · · · · · · · · · · · · · · · ·			
	_	PACE's response to and			
		ntation of all drills, tabletop			
		nergency events and revise			
		gency plan, as needed.			
	ĺ				
	*[For LTC Facilitie	es at §483.73(d):]			
	_	ity] must conduct exercises			
		ency plan at least twice per			
	_	announced staff drills using			
		ocedures. The [LTC facility,			
	ICF/IID] must do t	= -			
	_	an annual full-scale exercise			
	that is community				
		nunity-based exercise is not			
	` '	ıct an annual individual,			
	facility-based fund				
		ility] facility experiences an			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING COMPLETED		
		155702	B. WING		10/31/2023
NAME OF I	PROVIDER OR SUPPLIER		STREET	ADDRESS, CITY, STATE, ZIP COD	•
		•		VEST MATADOR ST	
APERIO	N CARE PERU		PERU,	IN 46970	
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	SIATE CONTINUE TOTAL
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
		nan-made emergency that			
		n of the emergency plan, the			
	LTC facility is exempt from engaging its next required a full-scale community-based or				
		based functional exercise			
		et of the emergency event.			
	_	dditional annual exercise			
		but is not limited to the			
	following:	sat to not infinited to the			
	_	scale exercise that is			
	` '	or an individual, facility			
	based functional e				
	(B) A mock disas	•			
	(C) A tabletop exercise or workshop that is led by a facilitator includes a group				
	discussion, using	- · · · · · · · · · · · · · · · · · · ·			
	_	emergency scenario, and a			
	set of problem sta				
		pared questions designed			
	to challenge an er	·			
	_	LTC facility] facility's			
		naintain documentation of			
		exercises, and emergency			
	events, and revise	e the [LTC facility] facility's			
	emergency plan, a	as needed.			
	*[For ICF/IIDs at §	5483.475(d)1:			
	-	CF/IID must conduct			
		he emergency plan at least			
		e ICF/IID must do the			
	following:	- ,			
	_	n annual full-scale exercise			
	that is community				
	_	nunity-based exercise is not			
		ict an annual individual,			
		ctional exercise; or.			
	-	experiences an actual			
	` '	ade emergency that requires			
		mergency plan, the ICF/IID			
		gaging in its next required			

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CENTERS FOR MEDICARE & MEDICAID SERVICES					(OMB NO. 0938-039		
STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DA	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	<u></u>	COM	MPLETED		
		155702	B. WING		10/3	31/2023		
			STREE	ET ADDRESS, CITY, STATE, ZIP	COD			
NAME OF	PROVIDER OR SUPPLIE	ER		WEST MATADOR ST	COD			
APERIO	N CARE PERU			U, IN 46970				
	1							
(X4) ID	SUMMARY	Y STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CO		(X5)		
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX	CROSS-REFERENCED TO THE		COMPLETION		
TAG		OR LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE		
		ınity-based or individual,						
	1	ectional exercise following the						
	onset of the eme	- ·						
	` '	dditional annual exercise						
	-	, but is not limited to the						
	following:							
	 (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, 							
	1	t emergency scenario, and a						
	•	atements, directed						
	1	epared questions designed						
	to challenge an e							
	. , , .	CF/IID's response to and						
		entation of all drills, tabletop						
		mergency events, and revise						
	the ICF/IID's eme	ergency plan, as needed.						
	*[For HHAs at §4	184 1021						
	-	ne HHA must conduct						
		the emergency plan at						
		he HHA must do the						
	following:							
	_	a full-scale exercise that is						
	community-base							
	1	community-based exercise						
	' '	, conduct an annual						
		y-based functional exercise						
	every 2 years; or							
		HA experiences an actual						
	' '	nade emergency that requires						
		emergency plan, the HHA is						
		aging in its next required						
		inity-based or individual,						
		actional exercise following the						

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onset of the emergency event.

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CENTERS FOI	R MEDICARE & MEDIC	CAID SERVICES			OMB NO. 0938-039
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA		CONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	<u></u>	COMPLETED
		155702	B. WING		10/31/2023
	PROVIDER OR SUPPLIE	R	1850 \	CADDRESS, CITY, STATE, ZIP COE WEST MATADOR ST , IN 46970	
	1			,	
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECT	
PREFIX	,	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP	PROPRIATE
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
		dditional exercise every 2			
	years, opposite th	ne year the full-scale or			
	functional exercis	e under paragraph (d)(2)(i)			
	of this section is	conducted, that may			
	include, but is not	t limited to the following:			
	(A) A second	I full-scale exercise that is			
	community-based	d or an individual,			
	facility-based fund	ctional exercise; or			
	(B) A mock d	lisaster drill; or			
	(C) A tableto	p exercise or workshop that			
	is led by a facilita	tor and includes a group			
	discussion, using	a narrated,			
	clinically-relevant	emergency scenario, and a			
	set of problem sta	atements, directed			
	messages, or pre	pared questions designed			
	to challenge an e	mergency plan.			
	(iii) Analyze the H	IHA's response to and			
	maintain docume	ntation of all drills, tabletop			
	exercises, and er	nergency events, and revise			
	the HHA's emerg	ency plan, as needed.			
	#F 000 101	00.000			
	*[For OPOs at §4	-			1
	. , , , ,	e OPO must conduct			
		the emergency plan. The			
	OPO must do the	•			
	1 ' '	er-based, tabletop exercise			
		ast annually. A tabletop			
	-	a facilitator and includes a			
		, using a narrated, clinically			
	_	ncy scenario, and a set of			1
	I .	nts, directed messages, or			1
		ns designed to challenge an			1
		If the OPO experiences an			1
		man-made emergency that			1
	1 -	n of the emergency plan, the			1
	-	om engaging in its next			1
	required testing e	xercise following the onset			1
	of the emergency	event.			
	(ii) Analyze the O	PO's response to and			

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maintain documentation of all tabletop

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CENTERS FOR MEDICARE & MEDICAID SERVICES						OM	B NO. 0938-039
	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
ANDILAN	or correction	155702	B. WI			10/31/2023	
NAME OF PROVIDER OR SUPPLIER APERION CARE PERU (X4) ID SUMMARY STATEMENT OF DEFICIENCIE		•	1850 W	ADDRESS, CITY, STATE, ZIP COD /EST MATADOR ST IN 46970			
` '	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG				TAG	DEFICIENCY)		DATE
TAG	exercises, and en the [RNHCl's and needed. *[RNCHIs at §40. (d)(2) Testing. The exercises to test to the total conduct a paperator of the emergency profession of the eme	the energency plan. The see following: er-based, tabletop exercise A tabletop exercise is a led by a facilitator, using a verelevant emergency et of problem statements, es, or prepared questions enge an emergency plan. NHCl's response to and intation of all tabletop in ergency events, and revise ergency plan, as needed. Eview and interview, the facility exercises to test the emergency every ear, including drills using the emergency or year, including drills using the emergency or facility must do the annual full-scale exercise that di; or ity-based exercise is not an annual individual, ional exercise. Ey experiences an actual natural gency that requires activation lan, the LTC facility is exempt	E 00)39	The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation and/or execution of this plan correction does not constitute admission or agreement by provider of the truth of the falleged or conclusions set for in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is	ne of n of ute the acts orth	11/17/2023
	community-based of full-scale functiona the onset of the act	ext required full-scale in a or individual, facility-based l exercise for 1 year following ual event. itional exercise that may			required by the provisions of federal and state law. Tag number: E039		

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include, but is not limited to the following:

a. A second full-scale exercise that is

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action(s) will be accomplished for

those residents found to have

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING COMPLETED				
		155702	B. W	/ING	_	10/31/2	023
				STREET A	ADDRESS, CITY, STATE, ZIP COD	•	
NAME OF P	PROVIDER OR SUPPLIEF	t	1850 WEST MATADOR ST				
APERION	N CARE PERU			PERU,	IN 46970		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	_	TAG	DEFICIENCY)		DATE
		or an individual, facility-based			been affected by the deficient		
	functional exercise.				practice;		
	b. A mock disaster drill; or c. A tabletop exercise or workshop that is led by a				No residents were affected b	-	
	-	-			this alleged deficient practic	e.	
		des a group discussion, using y-relevant emergency scenario,			II How other resider	nto	
		- ·					
	and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.				having the potential to be affe by the same deficient practice		
					be identified and what correct		
	(iii) Analyze the LTC facility's response to and				action(s) will be taken;	146	
	maintain documentation of all drills, tabletop				All residents had the potenti	al	
	exercises, and emergency events, and revise the				to be affected by this alleged		
		gency plan, as needed in			deficient practice.		
	accordance with 42 CFR 483.73(d)(2). This				The facility did participate in	a	
	deficient practice could affect all occupants.				facility based annual exercis	l l	
	*	•			but the documentation could		
	Findings include:				not be located at the time of		
					survey. Documentation has		
	Based on record rev	view and interview with the			been located. Please see		
	Maintenance Direct	tor (MD) on 10/31/23 at 02:00			attached.		
	p.m., no documenta	tion of a community based or					
	•	al exercise was available, but			III What measures will be put	into	
		ne annual tabletop exercise on			place and what systemic char	-	
		able for review. Based on			will be made to ensure that the		
		e of records review, the MD			deficient practice does not rec	l l	
	-	d not participate in a full-scale			Staff and maintenance direc		
		munity-based or facility based			to be in serviced on the facil	ity	
	-	facility based tabletop exercise			based annual exercise and		
	within the last 12 m	ontns.			documentation to be placed	l l	
	This find:	riannad with the Administrator			emergency plan binder. Nev	v	
	and MD at the exit	viewed with the Administrator			staff will be trained on the		
	and wid at the exit	COMETENCE.			manual/mock evacuation	ivo	
					during orientation by execut director/designee.	ive	
					IV How the corrective action	(e)	
					will be monitored to ensure the		
					deficient practice will not recu		
					i.e., what quality assurance	',	
					program will be put into place:		
					/b>	'	
					ļ ·		

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

PRINTED: 12/07/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155702 B. WING				(X3) DATE SURVEY COMPLETED 10/31/2023			
	PROVIDER OR SUPPLIER	3	STREET ADDRESS, CITY, STATE, ZIP COD 1850 WEST MATADOR ST PERU, IN 46970				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
K 0000 Bldg. 01	A Life Safety Code Licensure Survey w Department of Hea 483.90(a). Survey Date: 10/3: Facility Number: 0 Provider Number: 1 AIM Number: 2003 At this Life Safety Peru was found not Requirements for P Medicare/Medicaid Life Safety from Fi National Fire Prote Life Safety Code (I Health Care Occup This one story facil Type II222 constru The facility has a fi detection in the cor corridors and in the	Recertification and State vas conducted by the Indiana Ith in accordance with 42 CFR 1/2023	K 0				DAIL
	All areas where the access were sprinkl facility services we	residents have customary ered. All areas providing					

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: RU2821 Facility ID: 003130 If continuation sheet Page 12 of 45

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155702		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 10/31/2023	
	PROVIDER OR SUPPLIER	1850 W	ADDRESS, CITY, STATE, ZIP COD /EST MATADOR ST 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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
K 0211 SS=E Bldg. 01	NFPA 101 Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 Based on observation and interview, the facility failed to ensure 1 of 10 corridor means of egresses were continuously maintained free of obstructions. This deficient practice affects 10 residents. Findings include: Based on an observation during a tour of the facility with the Maintenance Director (MD) on 10/31/23 at 02:45 p.m., in the corridor to the Resident smoker exit, there were two residents in wheelchairs side by side in front of the exit doors obstructing the exit, allowing less than one foot of space to exit. Based on an interview at the time of observations, the MD agreed the wheelchairs were obstructing the Resident smoking exit in the corridor. This finding was reviewed with the Administrator and MD at the exit conference. 3.1-19(b)	K 0211	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 correction does not constitute admission or agreement by the provider of the truth of the far alleged or conclusions set for in the statement of deficiencies. The plan of correction is prepared and/of executed solely because it is required by the provisions of federal and state law. Tag number: K211 I What corrective action(s) we accomplished for those reside found to have been affected by deficient practice; No residents were affected by this alleged deficient practice. II How other residents having potential to be affected by the same deficient practice will be	of te he acts orth r s f sill be nts y the y e.	

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Event ID:

RU2821 Facility ID: 003130

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

PRINTED: 12/07/2023 FORM APPROVED OMB NO. 0938-039

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	TIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILI	DING	01	COMPLI	ETED
		155702	B. WING 10/31/2023				2023
		<u>I</u>	S	STREET A	DDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER	2			EST MATADOR ST		
APERION	N CARE PERU				N 46970		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	1	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PR	EFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION	Т	ΓAG			DATE
					identified and what corrective		
					action(s) will be taken;	_	
					All residents had the potentia		
					to be affected by this alleged		
					deficient practice. Residents		
					and staff educated on		
					appropriate place to wait to gout for designated smoking	, jo	
					time to ensure means of egre		
					is not compromised.		
					•		
					III What measures will be put		
					place and what systemic chan	-	
					will be made to ensure that the		
					deficient practice does not rec		
					During weekly rounds of faci	iity	
					by maintenance director, all		
					means of egress will be monitored to ensure		
					compliance and recorded the	,	
					results on the QA complianc		
					log.		
					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;		
					The administrator or designe		
					will audit the QA compliance		
					log monthly to ensure		
					compliance. The results of		
					these audits will be reviewed		
					in Quality Assurance Meeting		
					monthly x6 months or until a		
					average of 90% compliance of	or	
					greater is achieved x3		
					consecutive months. The Q	4	
					Committee will identify any		
					trends or patterns and make		

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

PRINTED: 12/07/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER) 155702		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	COM	TE SURVEY TPLETED 31/2023			
	PROVIDER OR SUPPLIEF	2	STREET ADDRESS, CITY, STATE, ZIP COD 1850 WEST MATADOR ST PERU, IN 46970					
(X4) ID PREFIX TAG	(EACH DEFICIEN	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION		CH DEFICIENCY MUST BE PRECEDED BY FULL		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
				recommendations to plan of correction as				
K 0222 SS=E Bldg. 01	be equipped with requires the use of egress side unless special locking and CLINICAL NEEDS LOCKING Where special locking and used, only one lock permitted on each be made for the raby: remote control locks or keys carnother such reliable staff at all times. 18.2.2.2.5.1, 18.2. 19.2.2.6 SPECIAL NEEDS ARRANGEMENT Where special lock safety needs of the the Clinical or Section are being met. In electrical locks that release upon loss building is protect automatic sprinkles space is protected detection system at an attended lock space); and both in the control of the contro	king arrangements for the eeds of the patient are cking device shall be a door and provisions shall apid removal of occupants I of locks; keying of all ited by staff at all times; or e means available to the						

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Event ID:

RU2821 Facility ID: 003130

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155702		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 10/31/2023		
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 1850 WEST MATADOR ST PERU, IN 46970			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
	systems installed 7.2.1.6.1 shall be assemblies servin contents in buildin an approved, super detection system automatic sprinkled 18.2.2.2.4, 19.2.2 ACCESS-CONTR LOCKING ARRAN Access-Controlled installed in accord be permitted. 18.2.2.2.4, 19.2.2 ELEVATOR LOBE LOCKING ARRAN Elevator lobby exist accordance with 7 on door assemblied throughout by an automatic fire detection automatic fire dete	selayed-egress locking in accordance with permitted on door g low and ordinary hazard gs protected throughout by ervised automatic fire or an approved, supervised or system. 2.4 OLLED EGRESS NGEMENTS I Egress Door assemblies ance with 7.2.1.6.2 shall 2.4 BY EXIT ACCESS NGEMENTS It access door locking in 1.2.1.6.3 shall be permitted ses in buildings protected approved, supervised ection system and an seed automatic sprinkler 2.4 on and interview, the facility means of egress through 2 of facility were readily accessible at a clinical diagnosis requiring measures. Doors within a gress shall not be equipped	K 0222	The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance.	11/01/2023	
	or key from the egropermitted by LSC 1 arrangements shall	that requires the use of a tool ess side unless otherwise 9.2.2.2.4. Door-locking be permitted in accordance This deficient practice could		Preparation and/or execution this plan of correction does no constitute admission or agree by the provider of the truth of	ot ment	

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Event ID:

RU2821

Facility ID: 003130

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			URVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	01	COMPLE	TED
		155702	B. W	ING		10/31/2	2023
NAME OF P	DOMDED OF CHIPPLYEE			STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIEF	C			EST MATADOR ST		
APERIO	N CARE PERU		_	PERU,	IN 46970		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR		ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	+	TAG	DEFICIENCY)	-4	DATE
	affect 10 residents in the vicinity of the Library exit door and the exit door by Room 101.				facts alleged or conclusions so forth in the statement of	et	
	exit door and the ex	it door by Room 101.			deficiencies. The plan of		
	Findings include:				correction is prepared and/or		
	8				executed solely because it is		
	Based on observation	on with the Maintenance			required by the provisions of		
	Director on 10/31/2	3 at 02:55 and 03:20 p.m., the			federal and state law.		
		Library and the exit by room 101					
		areas for residents without a a					
	_	equiring specialized security			Tag number: K222		
		rked as a facility exit, were					
		d, and could be opened by			I. What corrective action	, ,	
	entering a four-digit code on the access control pad, but the code was not posted at the exit.				will be accomplished for those	•	
	-	at the time of observation, the			residents found to have been	ioo	
		tor stated the code to open the			affected by the deficient practi No residents were	ice.	
		posted due to concern of			affected by this alleged		
	resident elopement.				deficient practice.		
					aonoioni praoticoi		
	The findings were r	reviewed with the			II. How other residents ha	aving	
	Administrator and I	Maintenance Director during			the potential to be affected by	the	
	the exit conference.				same deficient practice will be		
	2.4.40(1)				identified and what corrective		
	3.1-19(b)				action(s) will be taken;	. 1	
					42 residents had the potentia		
					to be affected by this alleged deficient practice. The door	,	
					codes were placed on all		
					appropriate exit doors.		
					appropriate over account		
					III. What measures will be	put	
					into place and what systemic		
					changes will be made to ensu		
					that the deficient practice does	s not	
					recur;		
					The maintenance director wi		
					check the exit doors to ensu	-	
					codes are posted at each exi	IT	
					door weekly and record the results on the on the QA		
			1		i results on the on the WA		

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Event ID:

RU2821 Facility ID: 003130

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

PRINTED: 12/07/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155702		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR A. BUILDING (01) COMPLETE B. WING 10/31/202			LETED		
	PROVIDER OR SUPPLIE	R	•	1850 W	ADDRESS, CITY, STATE, ZIP COD /EST MATADOR ST IN 46970	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	\TE	(X5) COMPLETION DATE
					compliance log.		
					IV. How the corrective action(s) will be monitored to ensure the deficient practice wont recur i.e., what quality assurance program will be puplace; The administrator or design will audit the QA compliance log monthly to ensure compliance. The results of these audits will be reviewed in Quality Assurance Meetin monthly x6 months or until a average of 90% compliance greater is achieved x3 consecutive months. The QC Committee will identify any trends or patterns and make recommendations to revise plan of correction as indicated.	t into ee d g an or A	
K 0223 SS=E Bldg. 01	enclosure, or hori or hazardous are and kept in the cl- open by a release 7.2.1.8.2 that auto doors throughout entire facility upor * Required manual * Local smoke de smoke passing the	closing Devices closing Devices closing Devices closing Devices closing Devices closing Device Self-closing closed position, unless held closed device complying with comatically closes all such the smoke compartment or					

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Event ID:

 $RU2821 \qquad \text{Facility ID:} \quad 003130$

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	01	COMPL		
		155702	B. W	B. WING			10/31/2023	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 1850 WEST MATADOR ST PERU, IN 46970					
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID		PROVIDENCE NEARLOS 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	ATE	COMPLETION	
TAG	REGULATORY OF	LATORY OR LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	.16	DATE	
	* Automatic sprink * Loss of power. 18.2.2.2.7, 18.2.2 Based on observation failed to ensure 1 or area enclosure are solosed position, unled device complying with the command staff in the staff of the command staff in the command staff in the staff of the command staff in the staff of the command staff in the command staff in the staff of the command staff in the co	cler system, if installed; and 2.8, 19.2.2.2.7, 19.2.2.2.8 on and interview, the facility f 1 kitchen door to a hazardous elf-closing and kept in the ess held open by a release with 7.2.1.8.2. This deficient t 40 residents in the Dining e kitchen. ons during a tour of the facility ce Director (MD) on 010/31/23 itchen contained over 62 king the kitchen a hazardous e kitchen from the Dining ing, but there was a kick stop ng the door to close. Based on e of observation, the MD door was unable to close due ding the door open.	K 0		The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution this plan of correction does not constitute admission or agreed by the provider of the truth of facts alleged or conclusions of 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. Tag number: K223 I. What corrective action will be accomplished for those residents found to have been affected by the deficient practic. No residents were affected by this alleged deficient practice will be identified and what corrective action(s) will be taken; 40 residents had the potentiat to be affected by this alleged deficient practice. Staff	of ot ment the et	11/17/2023	

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RU2821 Facility ID: 003130

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PRINTED: 12/07/2023 M APPROVED NO. 0938-039

PARTMENT OF HEALTH AND HUMAN SERVICES						
ENTERS FOR MEDICARE & MEDICAID SERVICES						
STATEMENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION	(X3) DATE S			

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155702		(X2) MULTIPLE CO A. BUILDING B. WING	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED 10/31/2023			
	ROVIDER OR SUPPLIEI	R	STREET ADDRESS, CITY, STATE, ZIP COD 1850 WEST MATADOR ST PERU, IN 46970			
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR	ION (X5) DBE COMPLETION	
TAG	•	R LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	DATE	
				educated on appropriate us kick stop on door containing door closure. III. What measures will be into place and what systemic changes will be made to ensure that the deficient practices not recur; During weekly rounds of far by maintenance director, doors containing door closwill be monitored to ensure compliance and record the results on the QA compliant log.	e put ctice cility sure	
				IV. How the corrective action(s) will be monitored to ensure the deficient practice not recur, i.e., what quality assurance program will be puplace; The administrator or design will audit the QA compliance log monthly to ensure compliance. The results of these audits will be reviewed in Quality Assurance Meetin monthly x6 months or until average of 90% compliance greater is achieved x3 consecutive months. The Committee will identify any trends or patterns and mak recommendations to revise plan of correction as indica	will ut into nee se ed ng an e or	

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Event ID:

RU2821

Facility ID: 003130

If continuation sheet

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155702		(X2) MULTIPLE CO A. BUILDING B. WING	<u></u>			
	PROVIDER OR SUPPLIER		1850 W	STREET ADDRESS, CITY, STATE, ZIP COD 1850 WEST MATADOR ST PERU, IN 46970		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE	
K 0291 SS=F Bldg. 01	duration is provide accordance with 7 18.2.9.1, 19.2.9.1 Based on observation failed to ensure 2 of tested monthly and the past year to ensulighting during peri-written record of visprovided. Section 7 testing shall be condiminimum of 3 week between tests, for multiple functional testing some a minimum of 1 1/2 system is battery period of visual inspection the owner for inspection.	g of at least 1-1/2-hour and automatically in 1.9. In and interview, the facility of 2 battery backup lights were annually for 90 minutes over are the light would provide ods of power outages and a sual inspections and tests was 1.9.3.1.1 (1) requires functional ducted monthly, with a as and a maximum of 5 weeks of less than 30 seconds, (3) shall be conducted annually for hours if the emergency lighting owered and (5) Written records and tests shall be kept by cition by the authority having efficient practice could affect all	K 0291	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 agreer 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.	t ment he	
	with the Maintenand Operated Emergency indicated two batters the emergency genes switch location. Battery operated emergency generated are not on a monthly Based on observation	riew on 10/31/23 at 11:15 a.m. ce Director (MD), the Battery by Light Test Log for 2023 by operated lights located at crator location and the transfer sed on an interview at the time e MD indicated the facility has ergency exit lighting at the or and transfer switch but they by test and annual testing log. ons during a tour of the facility 31/23 from 02:25 p.m. to 03:55		I What corrective action(s) will be accomplished those residents found to have been affected by the deficient practice; No residents were affected by this alleged deficient practice. Il How other resident	у e.	
	p.m., the facility ha	d 2 battery operated exit lights		having the potential to be affect	cted	

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Event ID:

RU2821 Facility ID: 003130

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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	01	COMPLETED
		155702	B. W	ING		10/31/2023
NAME OF P	DOWNED OF CHIRD IE	D	•	STREET A	ADDRESS, CITY, STATE, ZIP COD	
NAME OF P	PROVIDER OR SUPPLIE	K.	1850 WEST MATADOR ST			
APERION	N CARE PERU			PERU, IN 46970		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	,	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE
	located by the emergency generator and transfer switch. The lack of monthly and annual testing of				by the same deficient practice	
		·			be identified and what correct	ive
		ted exit lights was verified by pervisor at the time of record			action(s) will be taken; All residents had the potenti	al
		ations and acknowledged by			to be affected by this alleged	
		t the exit conference on			deficient practice. Maintenar	
	10/31/23 at 04:10 p				director updated battery	
	•				operated emergency light te	st
	3.1-19(b)				log monthly and annually to	
					include the lights located at	
					emergency generator and th	е
					transfer switch.	
					III What measures wil	l he
					put into place and what system	
					changes will be made to ensu	
					that the deficient practice doe	
					recur;	
					Maintenance will complete the	
					battery operated emergency	
					light test log monthly and	
					annually to ensure	
					compliance	
					IV How the corrective	
					action(s) will be monitored to	
					ensure the deficient practice v	vill
					not recur, i.e., what quality	
					assurance program will be pu	t into
					place;	
					The administrator or design	
					will audit the emergency ligh	nt
					test log monthly to ensure	
					compliance. The results of these audits will be reviewed	,
					in Quality Assurance Meetin	
					monthly x6 months or until a	-
					average of 90% compliance	
					greater is achieved x3	
					consecutive months. The Q	A

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	<u>01</u>	COMPL	ETED
		155702	B. W	ING		10/31/	2023
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 1850 WEST MATADOR ST PERU, IN 46970			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PROVIDER'S PLAN OF COR PREFIX (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A		COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					Committee will identify any trends or patterns and make recommendations to revise t plan of correction as indicate		
K 0293 SS=E Bldg. 01	accordance with 7 illumination also so lighting system. 19.2.10.1 (Indicate N/A in or occupancies with light where the line of each assed on observation failed to ensure 1 of outside of the facility facility exit. LSC 7 passage, or stairway way of exit access as so that it is likely to be identified by a sit EXIT. The NO EX in letters 2 inches his 3/8ths inch, and the NO, unless such sig sign. This deficient residents in the Dinit Findings include: Based on observation with the Maintenance at 02:40 p.m., in the	less than 30 occupants exit travel is obvious.) on and interview, the facility of 1 Dining room door to the exy were not mistaken as a .10.8.3.1 states any door, or that is neither an exit nor a not that is located or arranged be mistaken for an exit shall gen that reads as follows: NO IT sign shall have the word NO ligh, with a stroke width of word EXIT below the word is an approved existing practice could affect 40	K 0	293	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 agreer by the provider of the truth of the facts alleged or conclusions seforth 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.	t nent he	11/01/2023

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	OF CORRECTION	IDENTIFICATION NUMBER 155702	A. BUILDING B. WING	01	COMPLETED 10/31/2023
	PROVIDER OR SUPPLIER		1850 V	ADDRESS, CITY, STATE, ZIP COD VEST MATADOR ST IN 46970	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL . LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	interview at the time stated the Dining ro	NO EXIT" sign. Based on e of the observation, the MD om south door is not an exit to acknowledged the door did IT" sign posted.		I. What corrective action will be accomplished for those residents found to have been affected by the deficient practice. No residents were affected by this alleged deficient practice. II. How other residents had the potential to be affected by same deficient practice will be identified and what corrective action(s) will be taken; 40 residents had the potentit to be affected by this alleged deficient practice. Maintenar director ordered "No Exit" sand placed on the south doc in the dining room. III. What measures will be into place and what systemic changes will be made to ensuth the deficient practice doe recur; During weekly rounds by Maintenance director, all do leading to the outside will be observed to ensure NO EXIT posted on any door that is man exit to the public way and record the results on the QA compliance log.	ice; by se. aving the al d nce ign or sput ure s not ors e is ot d

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CENTERS FOR	MEDICARE & MEDIC				OMB NO. 0938-039			
STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	01	COMPLETED			
		155702	B. WING		10/31/2023			
		.00102	_		10/01/2020			
NAME OF P	ROVIDER OR SUPPLIEF			ADDRESS, CITY, STATE, ZIP COD VEST MATADOR ST				
APERION	N CARE PERU		PERU, IN 46970					
(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 APPROPRI	COMPLETION			
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE			
K 0341 SS=C Bldg. 01	NFPA 101 Fire Alarm System Fire Alarm System A fire alarm system accordance with N Code, and NFPA Code to provide e part of the building occupied, detection alarm control unit. detection is also in appliance circuit p supervising station Fire alarm system transmission path integrity.	n - Installation m is installed with systems approved for the purpose in IFPA 70, National Electric 72, National Fire Alarm ffective warning of fire in any g. In areas not continuously in is installed at each fire In new occupancy, installed at notification ower extenders, and in transmitting equipment. wiring or other is are monitored for	TAG	ensure the deficient practice of not recur, i.e., what quality assurance program will be puplace; The administrator or design will audit the QA compliance log monthly to ensure compliance. The results of these audits will be reviewe in Quality Assurance Meeting monthly x6 months or until average of 90% compliance greater is achieved x3 consecutive months. The QC Committee will identify any trends or patterns and make recommendations to revise plan of correction as indicated.	will ut into ee e d ng an or			
	18.3.4.1, 19.3.4.1 Based on observation	on and interview, the facility	K 0341	The facility requests paper	11/03/2023			

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failed to ensure 1 of 1 fire alarm systems was

continuously in proper operating condition.

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compliance for this citation.

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CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			Y		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	<u>01</u>	COMPLETED	
		155702	B. W	ING		10/31/2023	
			<u> </u>	CTREET /	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER				EST MATADOR ST		
ADEDION	LCARE REDIT						
APERIO	N CARE PERU			PERU,	IN 46970		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN 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'	COMI	PLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	D	ATE
	NFPA 72, National	Fire Alarm and Signaling Code,			This Plan of Correction is the		
		on 14.2.1.2.2 states system			center's credible allegation of		
	defects and malfunctions shall be corrected. This				compliance.		
		ould affect all residents, staff			· '		
	and visitors.				Preparation and/or execution o	of	
					this plan of correction does no		
	Findings include:				constitute admission or agreer		
					by the provider of the truth of t		
	Based on observation	on of the fire alarm control			facts alleged or conclusions se		
		strenance Director on 10/31/23			forth in the statement of	·	
	*	me on the display of the fire			deficiencies. The plan of		
	_	indicated the time to be 12:38.			correction is prepared and/or		
	Based on interview at the time of observation, the				executed solely because it is		
	Maintenance Director agreed the fire alarm control				required by the provisions of		
	panel had the wrong time and will need to be				federal and state law		
	changed.	s time and win need to be			leacial and state law		
	changea.						
	The finding was rev	riewed with the Maintenance			Tag number: K341		
	_	histrator during the exit			Tag number. N341		
	conference.	instrator during the exit					
	conference.				What corrective		
	3.1-19(b)				action(s) will be accomplished	for	
	3.1-17(0)				those residents found to have		
					been affected by the deficient		
					practice;		
					No residents were affected by		
					this alleged deficient practice	·-	
					II How other residen	.	
					having the potential to be affect		
					by the same deficient practice be identified and what correcti		
						/e	
					action(s) will be taken;		
					All residents have the potent	aı	
					to be affected. Maintenance		
					director contacted fire		
					monitoring system and had t	ne	
					time updated to the correct		
					time.		

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155702	B. W			10/31/	
		<u> </u>					
NAME OF F	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD		
					EST MATADOR ST		
APERIO	N CARE PERU			PERU,	IN 46970		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	16	DATE
					III What measures wil	be	
					put into place and what syster	nic	
					changes will be made to ensu		
					that the deficient practice does		
					recur;		
					Fire panel maintenance will b	е	
					added to monthly preventative		
					maintenance log to be		
					completed by maintenance		
					director to ensure correct tin	1e	
				is verified. and results record	ded		
					on the QA compliance log.		
					_		
					IV How the corrective		
					action(s) will be monitored to		
					ensure the deficient practice w	/ill	
					not recur, i.e., what quality		
					assurance program will be put	into	
					place;		
					The administrator or designe	e	
					will audit the QA compliance		
					log monthly to ensure		
					compliance. The results of		
					these audits will be reviewed		
					in Quality Assurance Meeting		
					monthly x6 months or until a	-	
					average of 90% compliance		
					greater is achieved x3		
					consecutive months. The Q	4	
					Committee will identify any		
					trends or patterns and make		
					recommendations to revise t	he	
					plan of correction as indicate		
K 0353	NFPA 101						
SS=C		- Maintenance and Testing					

Sprinkler System - Maintenance and Testing

Bldg. 01

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OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 155702 B. WING 10/31/2023 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1850 WEST MATADOR ST APERION CARE PERU PERU. IN 46970 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked b) Who provided system test c) Water system supply source Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on observation and interview, the facility K 0353 11/03/2023 The facility requests paper failed to ensure 1 of 1 sprinkler systems were compliance for this citation. provided with spare sprinklers, a spare sprinkler cabinet large enough to fit all spare sprinkler This Plan of Correction is the heads, and a sprinkler wrench on the premises. center's credible allegation of NFPA 25, Standard for the Inspection, Testing, compliance. and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.4.1.4 states a Preparation and/or execution of supply of spare sprinklers (never fewer than six) this plan of correction does not shall be maintained on the premises so that any constitute admission or agreement sprinklers that have been operated or damaged in by the provider of the truth of the any way can be promptly replaced. The sprinklers facts alleged or conclusions set shall correspond to the types and temperature forth in the statement of ratings of the sprinklers on the property. The deficiencies. The plan of sprinklers shall be kept in a cabinet located where correction is prepared and/or the temperature in which they are subjected will at executed solely because it is no time exceed 100 degrees Fahrenheit. A special required by the provisions of sprinkler wrench shall be provided and kept in the federal and state law

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cabinet to be used in the removal and installation of sprinklers. This deficient practice could affect

all residents and staff in the facility.

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Tag number: K353

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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	01	COMPL	ETED
		155702	B. W	ING		10/31/	2023
			<u> </u>	STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIEF	₹			/EST MATADOR ST		
ΔPERI∩N	N CARE PERU				IN 46970		
AI LINIOI	• OAKE I EKO			i Livo,	114		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	1	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	Findings include:				I. What corrective action	` '	
					will be accomplished for those	;	
		on with the Maintenance			residents found to have been		
		3 at 03:35 p.m., the spare			affected by the deficient practi	ice;	
	-	the riser room was not large			No residents were		
	enough to contain all sprinkler heads and prevent				affected by this alleged		
		kler heads. When the cabinet			deficient practice.		
		as opened, the cabinet]		
	-	tler heads in protected slots			II. How other residents ha	-	
	and 4 sprinkler heads positioned on the shelf, not in protected slots, inside the cabinet. Based on				the potential to be affected by		
	•	e of the observations, the			same deficient practice will be identified and what corrective	;	
		tor agreed the cabinet was not					
		itain all spare sprinkler heads.			action(s) will be taken; All residents had the potenti	ol.	
	large enough to con	ttam an spare sprinkler heads.			to be affected by this alleged		
	This finding was re	viewed with the Maintenance			deficient practice. All spare	4	
	-	nistrator during the exit			sprinkler heads were inspec	tod	
	conference.	institutor during the exit			with no concerns found and		
	comercine.				sprinkler heads were stored	an	
	3.1-19(b)				appropriately to prevent any		
	212 27 (2)				potential damage.		
					Potential damage.		
					III. What measures will be	put	
					into place and what systemic		
					changes will be made to ensu	re	
					that the deficient practice does		
					recur;		
					Spare sprinkler heads		
					maintenance was added to the	he	
					preventive maintenance log	to	
					be completed by the		
					maintenance director and wi	II	
					be verified monthly and reco	ord	
					the results on the QA		
					compliance log.		
					IV. How the corrective		
					action(s) will be monitored to		
					ensure the deficient practice v	vill	

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CENTERS FOR MEDICARE & MEDICAID SERVICES							IB NO. 0938-039
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	01	COMPL	LETED
		155702	B. W	ING		10/31/	/2023
				CEREE	ADDRESS SITU STATE TIP SOD		
NAME OF I	PROVIDER OR SUPPLIER	t			ADDRESS, CITY, STATE, ZIP COD		
ADEDIO	U OADE DEDU				VEST MATADOR ST		
APERIO	N CARE PERU			PERU, IN 46970			
(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
					not recur i.e., what quality assurance program will be put place; The administrator or designed will audit the QA compliance log monthly to ensure compliance. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until a average of 90% compliance of greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise to plan of correction as indicated.	ee i g un or A	
K 0355 SS=E Bldg. 01	installed, inspecte accordance with N Portable Fire Extir 18.3.5.12, 19.3.5. Based on observation failed to inspect 3 of extinguishers each in Portable Fire Extinguishers slighter extinguishers	nguishers guishers are selected, d, and maintained in NFPA 10, Standard for nguishers. 12, NFPA 10 on and interview, the facility of over 20 portable fire month. NFPA 10, Standard for guishers, Section 7.2.1.2 states hall be inspected either has of an electronic device / m of 30-day intervals. Section c inspection or electronic extinguishers shall include a c following items:	K 0	355	The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution this plan of correction does no constitute admission or agree by the provider of the truth of the compliance.	of ot ment	11/01/2023

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(2) No obstruction to access or visibility

operable range or position

(3) Pressure gauge reading or indicator in the

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facts alleged or conclusions set

forth in the statement of

deficiencies. The plan of

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	T OF HEALTH AND HU R MEDICARE & MEDIC					FO	RM APPROVED
STATEME	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155702		A. B	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED 10/31/2023	
	PROVIDER OR SUPPLIEI	3	STREET ADDRESS, CITY, STATE, ZIP COD 1850 WEST MATADOR ST PERU, IN 46970				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY O	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION Lined by weighing or hefting for		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) correction is prepared and/or	ΓE	(X5) COMPLETION DATE
	(5) Condition of tir nozzle for wheeled	extinguishers, and pump tanks es, wheels, carriage, hose, and extinguishers			executed solely because it is required by the provisions of federal and state law		
	(6) Indicator for nonrechargeable extinguishers using push to-test pressure indicators. Section 7.2.4.1 states personnel making manual inspections shall keep records of all fire extinguishers inspected, including those found to require corrective action. Section 7.2.4.3 requires where at least monthly manual inspections are conducted, the date the manual inspection was performed and the initials of the person performing the inspection shall be recorded. Section 7.2.4.4 requires where manual inspections are conducted, records for manual inspections				I What corrective action(s) will be accomplished those residents found to have been affected by the deficient practice; No residents were affected by this alleged deficient practice. II How other resident having the potential to be affected.	y e. ts cted	
	extinguisher, on an maintained on file, Section 7.2.4.5 required demonstrate that at inspections have be practice could affect Findings include: Based on observati	on during a tour of the facility			by the same deficient practice be identified and what correcting action(s) will be taken; All residents had the potentiat to be affected by this alleged deficient practice. Maintenan director inspected and documented on both fire extinguishers located in the mechanical room and therapy room.	ve al ce	
		oce Director (MD) on 10/31/23 03:35 p.m., the monthly			III What measures will	be	

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previously mentioned.

inspection tag on the fire extinguisher located in

the mechanical room lacked documentation of a

monthly inspections for August and September of

2023 and the fire extinguisher in Therapy lacked documentation of monthly inspections for

March-September 2023. Based on interview at the

extinguishers located in the mechanical room and

time of observation, the MD confirmed the fire

Therapy lacked the monthly inspections

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put into place and what systemic

changes will be made to ensure

The fire extinguishers located

in the mechanical room and

to the monthly preventative

maintenance log and will be

inspected monthly by

the therapy room were added

that the deficient practice does not

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

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155702		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 10/31/2023	
	PROVIDER OR SUPPLIER		1850 V	ADDRESS, CITY, STATE, ZIP COD VEST MATADOR ST IN 46970	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
	This finding was re and MD at the exit	viewed with the Administrator conference.		Maintenance director who w also record the results on the QA compliance log	
	3.1-19(b)			IV How the corrective action(s) will be monitored to ensure the deficient practice wont recur, i.e., what quality assurance program will be purplace; The administrator or designe will audit the QA compliance log monthly to ensure compliance. The results of these audits will be reviewed in Quality Assurance Meetin monthly x6 months or until a average of 90% compliance greater is achieved x3 consecutive months. The QC Committee will identify any trends or patterns and make recommendations to revise plan of correction as indicated.	vill t into ee d g an or A
K 0374 SS=E Bldg. 01	Barrie Subdivision of Bui Barrier Doors 2012 EXISTING Doors in smoke be solid bonded wood construction that re	Iding Spaces - Smoke Iding Spaces - Smoke arriers are 1-3/4-inch thick d-core doors or of esists fire for 20 minutes. //e plates of unlimited height			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 155702 B. WING 10/31/2023 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1850 WEST MATADOR ST APERION CARE PERU PERU. IN 46970 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 Based on observation and interview, the facility K 0374 11/03/2023 The facility requests paper failed to ensure 1 of 5 sets of smoke barrier doors compliance for this citation. would restrict the movement of smoke for at least 20 minutes. LSC 19.3.7.8 requires doors in smoke This Plan of Correction is the barriers shall comply with LSC Section 8.5.4. LSC center's credible allegation of 8.5.4.1 requires doors in smoke barrier shall close compliance. the opening leaving only the minimum clearance necessary for proper operation. This deficient Preparation and/or execution of practice could affect 30 residents in two smoke this plan of correction does not compartments. constitute admission or agreement by the provider of the truth of the Findings include: facts alleged or conclusions set forth in the statement of Based on observation with the Maintenance deficiencies. The plan of Director on 010/31/23 at 03:15 p.m., the sets of correction is prepared and/or smoke barrier doors by room 103 would not fully executed solely because it is close due to the coordinating device on the door required by the provisions of frame not correctly working. When tested, the federal and state law coordinating device would hold one door open when the door without the astragal was shut first. Tag number: K374 This condition creates a one-inch gap between the doors when shut. Based on interview during What corrective action(s) the time of observations, the Maintenance will be accomplished for those Director agreed the coordinating device was not residents found to have been functioning properly and not allowing the doors affected by the deficient practice; to completely shut. No residents were affected by this deficient The finding was reviewed with the Maintenance practice. Director and the Administrator during the exit conference. How other residents having the potential to be affected by the

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3.1-19(b)

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same deficient practice will be

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

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER) 155702		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING (X3) DATE SURVEY COMPLETED 10/31/2023				
NAME OF P	ROVIDER OR SUPPLIEF			EEET ADDRESS, CITY, STATE, ZIP COD 50 WEST MATADOR ST		
APERION	N CARE PERU		PERU, IN 46970			
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTI	ON (X5)	
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	PREF TAC	CROSS-REFERENCED TO THE APPRO	PRIATE COMPLETION DATE	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAC		ential ged crier ensure rier as the se d. be put hic houre does not to be log QA to be will be ence of wed eting	
l			1	avorage of 90% complian	co or	

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PRINTED: 12/07/2023

DEPARTMEN CENTERS FOI	FORM APPROVED OMB NO. 0938-039					
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155702	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 10/31/2023	
NAME OF 1	PROVIDER OR SUPPLIEF	.		TADDRESS, CITY, STATE, ZIP COD WEST MATADOR ST		
APERIO	N CARE PERU			, IN 46970		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE	
				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 indicate	ne	
K 0712 SS=F Bldg. 01	alarm signal and so conditions. Fire did and unexpected till conditions, at least The staff is familia aware that drills a routine. Where did 9:00 PM and 6:00 announcement madible alarms. 19.7.1.4 through a Based on record revenue.	ay be used instead of 19.7.1.7 view and interview, the facility	K 0712	The facility requests paper	11/17/2023	
	quarters. LSC 19.7. conducted quarterly facility personnel (i engineers, and adm	re drills on each shift for 2 of 4 1.6 states drills shall be 7 on each shift to familiarize nurses, interns, maintenance inistrative staff) with the ncy action required under		compliance for this citation. This Plan of Correction is the center's credible allegation of compliance.		
	varied conditions. I all staff and residen Findings include:	This deficient practice affects its.		Preparation and/or execution of this plan of correction does not constitute admission or agreen by the provider of the truth of the	: nent	
	Based on records re	eview with the Maintenance 0/31/23 at 11:30 a.m., the		facts alleged or conclusions se forth in the statement of deficiencies. The plan of		

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completed fire drill:

following shifts were missing documentation of a

a) A third shift fire drill in the first quarter of 2023

was not completed within the time frame (third

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federal and state law

correction is prepared and/or

executed solely because it is

required by the provisions of

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING 01 COMPLETED					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155702	A. BUILDING 01 COMPLETED B. WING 10/31/2023				
		100/02	D. W.			10/31/	2023
NAME OF P	ROVIDER OR SUPPLIER	t			ADDRESS, CITY, STATE, ZIP COD VEST MATADOR ST		
APERION	N CARE PERU				IN 46970		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	,	CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	.ΤE	COMPLETION DATE
IAG		as being 10 p.m. to 6 a.m. but		IAG			DATE
		eted at 9 p.m.), no scenario, and					
	signal not verified.				Tag number: 712		
		fire drills in the second					
	quarter of 2023 did				I. What corrective action		
	c) The first shift fire drill in the third quarter of 2023 was not completed within the time frame (day				will be accomplished for those residents found to have been	;	
	-	as being 6 a.m. to 2 p.m. but			affected by the deficient pract	ice:	
the drill was completed at 2:30 p.m.				No residents were	-,		
		at the time of record review,			affected by this alleged		
	the Maintenance Director stated the drills were				deficient practice		
	completed and said that the aforementioned concerns need to be corrected.				II I I I I I I I I I I I I I I I I I I		
	concerns need to be	corrected.			II. How other residents hat the potential to be affected by	~	
	3.1-19(b)				same deficient practice will be		
					identified and what corrective		
					action(s) will be taken;		
					All residents have the potent		
					to be affected by this alleged		
					deficient practice. A fire drill with all the required		
					components will be conduct	ed.	
					III. What measures will be	put	
					into place and what systemic		
					changes will be made to ensu		
					that the deficient practice doe recur;	2 1101	
					The maintenance director an	ıd	
					maintenance assistant was		
					inserviced on all the require		
					components of a fire drill. Fi	re	
					drills will be completed by maintenance director or		
					maintenance director or maintenance assistant to		
					include conducting fire drills	;	
					on all three shifts quarterly.		
					IV. How the corrective		
					action(s) will be monitored to		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	LETED
		155702	B. W			10/31/	
					-		
NAME OF P	ROVIDER OR SUPPLIEF	8			ADDRESS, CITY, STATE, ZIP COD		
			1850 WEST MATADOR ST				
APERION	N CARE PERU		PERU, IN 46970				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	.TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	.16	DATE
					ensure the deficient practice v	vill	
					not recur i.e., what quality		
					assurance program will be put	t into	
					place;		
					The administrator or designe	ee	
					will audit the fire drill log		
					monthly to ensure all require	∍d	
					components of a fire drill are		
					followed.	•	
					The results of these audits w	vill	
					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 t	tho	
					plan of correction as indicate	au.	
K 0761							
SS=F							
Bldg. 01							
Blug. 01	Based on observation	on, records review, and	K 0	761	The facility requests paper		11/17/2023
		ty failed to ensure annual	KU	/01	compliance for this citation.		11/1//2023
		ng of fire door assemblies			compliance for this citation.		
	-	accordance of LSC 19.1.1.4.1.1			This Plan of Correction is the		
	•	enings in dividing fire barriers					
		4.1 shall be permitted only in			center's credible allegation of		
		be protected by approved			compliance.		
		or assemblies. (See also Section			Propagation and/or avacution	of	
		prenings required to have a fire			Preparation and/or execution		
	1				this plan of correction does no		
		Table 8.3.4.2 shall be			constitute admission or agree		
		ved, listed, labeled fire door			by the provider of the truth of t		
		window assemblies and their			facts alleged or conclusions so	et	
		lware, including all frames,			forth in the statement of		
	closing devices, and	chorage, and sills in	1		deficiencies. The plan of		I

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accordance with the requirements of NFPA 80,

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correction is prepared and/or

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12/07/2023 PRINTED: FORM APPROVED

OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 155702 B. WING 10/31/2023 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1850 WEST MATADOR ST APERION CARE PERU PERU. IN 46970 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE Standard for Fire Doors and Other Opening executed solely because it is Protectives, except as otherwise specified in this required by the provisions of Code. NFPA 80 5.2.1 states fire door assemblies federal and state law shall be inspected and tested not less than annually, and a written record of the inspection Tag number: 761 shall be signed and kept for inspection by the AHJ. NFPA 80, 5.2.4.1 states fire door assemblies What corrective action(s) shall be visually inspected from both sides to will be accomplished for those assess the overall condition of door assembly. residents found to have been NFPA 80, 5.2.4.2 states as a minimum, the affected by the deficient practice; following items shall be verified: No residents were (1) No open holes or breaks exist in surfaces of affected by this alleged either the door or frame. deficient practice (2) Glazing, vision light frames, and glazing beads are intact and securely fastened in place, if so How other residents having equipped. the potential to be affected by the (3) The door, frame, hinges, hardware, and same deficient practice will be noncombustible threshold are secured, aligned, identified and what corrective and in working order with no visible signs of action(s) will be taken; All residents have the potential (4) No parts are missing or broken. to be affected by this alleged (5) Door clearances do not exceed clearances deficient practice. The fire door listed in 4.8.4 and 6.3.1.7. assemblies will be scheduled (6) The self-closing device is operational; that is, to be tested and completed the active door completely closes when operated prior to 11/19/23 from the full open position. (7) If a coordinator is installed, the inactive leaf What measures will be put closes before the active leaf. into place and what systemic (8) Latching hardware operates and secures the changes will be made to ensure ` door when it is in the closed position. that the deficient practice does not (9) Auxiliary hardware items that interfere or recur: prohibit operation are not installed on the door or The maintenance director was frame. inserviced on the requirement (10) No field modifications to the door assembly for fire door assemblies to be have been performed that void the label. inspected annually. An annual (11) Gasketing and edge seals, where required, are fire door assembly inspection

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Findings include:

inspected to verify their presence and integrity.

This deficient practice could affect all residents.

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director.

log was created and will be

completed by the maintenance

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155702		A. BUILDING B. WING	B. WING					
	PROVIDER OR SUPPLIER		1850 V	STREET ADDRESS, CITY, STATE, ZIP COD 1850 WEST MATADOR ST PERU, IN 46970				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	(X5) COMPLETION DATE			
	Director (MD) on 10 annual inspection for available for review annual fire door inspon interview at the tobservation, the ME the annual fire door	riew with the Maintenance 0/31/23 documentation of an or the fire door assemblies was but was dated 10/07/22. The pection was past due.Based time of records review and 0 stated he was unaware that inspection was required.		IV. How the corrective action(s) will be monitored to ensure the deficient practice not recur i.e., what quality assurance program will be puplace; The administrator will audit the door assembly inspection log annually to ensure the inspection completed annually. The results of these audits be reviewed in Quality Assurance Meeting monthly months or until an average 90% compliance or greater achieved x3 consecutive months. The QA Committed will identify any trends or patterns and make recommendations to revise plan of correction as indical	will ut into ne fire ction will / x6 of is e			
K 0914 SS=F Bldg. 01	Testing Electrical Systems Testing Hospital-grade reclocations and whe anesthesia is adminitial installation, radditional testing idefined by docume Receptacles not list these locations are exceeding 12 mon (LIM), if installed, a	s - Maintenance and s - Maintenance and septacles at patient bed re deep sedation or general inistered, are tested after replacement or servicing. is performed at intervals ented performance data. sted as hospital-grade at the tested at intervals not on the service of the ser						

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155702	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE A. BUILDING 01 COMPLETED B. WING 10/31/2023				
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 1850 WEST MATADOR ST PERU, IN 46970				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE		
	activates both visu LIM circuits with a manual test is per than or equal to 1: tested per 6.3.3.3 renovation to the or Records are main associated repairs containing date, ro results. 6.3.4 (NFPA 99) Based on observation interview, the facility grade electrical recor rooms were tested at Health Care Facilitity 6.3.4.1.3 states rece hospital-grade, at pel locations where dece anesthesia is admin intervals not exceed Section 6.3.3.2, Rec Rooms requires the receptacle shall be or The continuity of the electrical receptacle polarity of the hot a each electrical receptacle receptacles) shall be ounces). This deficit residents. Findings include: Based on observation with the Maintenan	on, record review and ty failed to ensure non-hospital eptacles in resident sleeping tt least annually. NFPA 99, es Code 2012 Edition, Section	K 0914	This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution this plan of correction does not constitute admission or agreed by the provider of the truth of facts alleged or conclusions of 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 Tag number: K914 I. What corrective action will be accomplished for those residents found to have been affected by the deficient practice. No residents were affected by this alleged deficient practice	of ot ement the set		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155702		A. BUILDING <u>01</u> COMPLET		(X3) DATE SURVEY COMPLETED 10/31/2023				
	PROVIDER OR SUPPLIER		1850 V	STREET ADDRESS, CITY, STATE, ZIP COD 1850 WEST MATADOR ST PERU, IN 46970				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE			
IAU	contained four to ei electrical receptacle 02:15 p.m., the anni for non-hospital grapast due. The provinceceptacle tested wa interview at the time records review, the electrical receptacle rooms were not hos testing per NFPA 9 requirements was p	ght non-hospital-grade es. Based on records review at ual electrical receptacle testing de electrical receptacles was ded documentation of the last as dated 10/18/22. Based on e of the observation and MD confirmed all of the es in the resident sleeping pital-grade and stated annual 9, Receptacle Testing ast due. viewed with the Administrator	IAG	II. How other residents he the potential to be affected by same deficient practice will be identified and what corrective action(s) will be taken; All residents have the potent to be affected by this allege deficient practice. All outlets were tested as for polarity a retention with all outlets passing and the form show the room, location and pass/fail. III. What measures will be into place and what systemic changes will be made to ensith that the deficient practice docrecur; The maintenance director winserviced on outlet testing the form changed to add da room, location and pass/fail be completed by the maintenance director or designee. Results will be recorded on the QA compliance log. IV. How the corrective action(s) will be monitored to ensure the deficient practice not recur i.e., what quality assurance program will be puplace; The administrator or design will audit the QA compliance log monthly to ensure compliance. The results of these audits will be revieween	aving y the e e tial d s ind ing e put ure es not ras and te, to will wit into ee e			

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		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155702	A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 10/31/2023	
NAME OF PROVIDER OR SUPPLIER APERION CARE PERU				1850 W	ADDRESS, CITY, STATE, ZIP COD /EST MATADOR ST IN 46970		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE ((X5) COMPLETION DATE
					in Quality Assurance Meetin monthly x6 months or until a average of 90% compliance greater is achieved x3 consecutive months. The Q Committee will identify any trends or patterns and make recommendations to revise plan of correction as indicate	an or A	
K 0923 SS=E Bldg. 01	NFPA 101 Gas Equipment - Cylinder and Container Storag Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is						

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AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155702	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 10/31/2023	
NAME OF PROVIDER OR SUPPLIER APERION CARE PERU		STREET ADDRESS, CITY, STATE, ZIP COD 1850 WEST MATADOR ST PERU, IN 46970				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE	
	room, where the sa a minimum "CAU" STORED WITHIN Storage is planned order of which the supplier. Empty of from full cylinders cylinders with intee threshold pressure established. Empavoid confusion. Care protected from 11.3.1, 11.3.2, 11.99) Based on observation failed to ensure 7 orgases such as oxyge falling. NFPA 99, 12012 Edition, Section onflammable gase (300 cubic feet) but (3000 cubic feet) shathrough 11.3.2.3. A cylinder or contained 11.6.2.3. Section 1 cylinders shall be pin a proper cylinder practice could affect compartments. Findings include: Based on observation with the Maintenan at 03:00 and 03:05 cylinders were standoxygen storage/trantesident room 127 wer	d so cylinders are used in y are received from the ylinders are segregated. When facility employs gral pressure gauge, a e considered empty is ty cylinders are marked to Cylinders stored in the open	K 0923	The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution this plan of correction does n constitute admission or agree by the provider of the truth of facts alleged or conclusions of 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 Tag number: K923 I. What corrective action will be accomplished for thos residents found to have been	of ot ement the set	

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE S		URVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPLE	ETED
		155702	B. W	B. WING 10/3		10/31/2	2023
		l .		STREET /	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIEF	2			EST MATADOR ST		
ΔPERI∩N	N CARE PERU				IN 46970		
AI LINOI	• OAKE I EKO			i Livo,			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	+	TAG	DEFICIENCY)		DATE
		at the time of observations,			affected by the deficient practi	ce;	
		ged six 'E' type oxygen			No residents were		
		gen storage/trans-filling room		affected by this alleged			
		room 127 were not properly			deficient practice.		
		ed in a proper cylinder stand or			l		
	cart.				II. How other residents ha	-	
	Tl C 1'	diamental and all all and all all and all all all all all all all all all al			the potential to be affected by		
	-	viewed with the Administrator			same deficient practice will be		
	and the MD during	the exit conference.			identified and what corrective		
	3.1-19(b)				action(s) will be taken; 15 residents have the potent	ial	
	3.1-19(0)				to be affected by this alleged		
					deficient practice. The oxyge		
					tanks were secured	;11	
					appropriately.		
					арргорпасету.		
					III. What measures will be	nut	
					into place and what systemic	Put	
					changes will be made to ensu	re	
					that the deficient practice does	I	
					recur;	1100	
					All the Oxygen cylinders wer	·e	
					properly secured. The nursir	I	
					staff were inserviced on proj	_	
					oxygen storage. The		
					maintenance director will		
					make weekly rounds to ensu	re	
					oxygen is properly stored an		
					will document the results on		
					the and also recorded on the		
					QA compliance log		
					IV. How the corrective		
					action(s) will be monitored to		
					ensure the deficient practice v	vill	
					not recur i.e., what quality		
					assurance program will be put	into	
					place;		
					The administrator or designe	e	

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

PRINTED: 12/07/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155702	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE COMPL 10/31/	LETED
NAME OF PROVIDER OR SUPPLIER APERION CARE PERU			STREET ADDRESS, CITY, STATE, ZIP COD 1850 WEST MATADOR ST PERU, IN 46970			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
				will audit the QA compliance log monthly to ensure compliance. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until a average of 90% compliance of 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.	I g in or A	

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