STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	04/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
APERION ESTATES PERU, LLC	1200 KITTY HAWK DRIVE PERU, IN 46970

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R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included the Investigation of Complaint IN00399011. Complaint IN00399011- No deficiencies related to the allegations are cited. Survey dates: April 5 and 6, 2023 Facility number: 013327 Residential Census: 31 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed 4/20/2023.	R 0000	Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. The plan of correction is prepared and submitted because of requirements under state and federal law. Please accept this plan of correction for this survey. The documentation serves to confirm the facility's allegation of compliance. Thus, the facility respectfully requests the granting of paper compliance.	
R 0216 Bldg. 00	410 IAC 16.2-5-2(c)(1-4)(d) Evaluation - Noncompliance (c) The scope and content of the evaluation shall be delineated in the facility policy manual, but at a minimum the needs assessment shall include an evaluation of the following: (1) The resident ' s physical, cognitive, and mental status. (2) The resident ' s independence in the activities of daily living. (3) The resident ' s weight taken on admission and semiannually thereafter. (4) If applicable, the resident ' s ability to self-administer medications. (d) The evaluation shall be documented in writing and kept in the facility. Based on record review and interview, the facility	R 0216	I. **What corrective action(s) will be**	05/12/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Deana Collins	Regional Nurse Consultant	05/15/2023

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	failed to ensure admission weights and semi annual weights were completed for 2 of 8 residents reviewed for weights. (Residents E & B) Findings include: 1. A closed record review was completed on 4/5/2023 at 3:20 P.M. Resident E's diagnoses included, but were not limited to diabetes, obesity, gout, bipolar, and chronic obstructive pulmonary disease. During an interview, on 4/6/2023 at 11:29 A.M., the Administrator indicated the resident had refused to be weighed and was unsure if the refusals had been documented. The record lacked an admission weight and/or documentation of weight refusals by the resident. 2. During a record review, on 4/5/2023 at 2:02 P.M., Resident B had no admission weight documented and no semiannual weights were found. During an interview, on 4/5/2023 at 2:30 P.M., the E.D. (Executive Director) indicated weights were kept in a weight book which was provided. No weights for this resident were found in the weight book. During an interview, on 4/6/2023 at 11:07 A.M., the E.D. indicated they do not have a weight policy, they just follow the regulations.		**accomplished for those residentsfound to have been affected by the deficient practice**; Residents E and B had no adverse outcomes related to the cited practice. Residents E and B had their weights entered in PCC. II. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken**; All residents have the potential to be affected by the alleged practice. A full house audit was completed to ensure all residents had a current weight in PCC. Any discrepancies were immediately corrected. III. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** RNC/designee to educate nursing staff on obtaining weights upon admission and semiannually thereafter. **IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality**	

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			assurance program will be put into place; DON/designee to audit new admissions to ensure an admission weight was obtained. Audits will be conducted to ensure weights are obtained semi annually on all residents. Audits will be completed weekly x 3 months, then monthly. The results of these audits will be reviewed by the RNC monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The RNC will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	
R 0275 Bldg. 00	410 IAC 16.2-5-5.1(h) Food and Nutritional Services - Deficiency (h) Diet orders shall be reviewed and revised by the physician as the resident ' s condition requires. Based on interview and record review, the facility failed to obtain diet orders upon admission for 2 out of 5 residents reviewed for diet orders. (Residents B and E) Findings include: 1. During a record review, on 4/5/2023 at 2:02 P.M., a diet order for Resident B was not found. During an interview, on 4/5/2023 at 2:30 P.M., the E.D. (Executive Director) indicated the resident did not have a diet order upon admission but should have.	R 0275	**I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice**; Diet orders were obtained and entered into PCC for residents B and E. Residents B and E had no adverse outcomes related to the cited practice. II. **How other residents having the potential to be affected by the same deficient practice will be identified and**	05/12/2023

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	2. A closed record review was completed on 4/5/2023 at 3:20 P.M. Resident E's diagnoses included, but were not limited to diabetes, obesity, gout, bipolar, and chronic obstructive pulmonary disease. Resident E's Physician Orders lacked a diet order from admission. During an interview, on 4/6/2023 at 11:29 A.M., the Administrator indicated the resident should have had a diet order when admitted. On 4/6/2023 at 11:39 A.M., the Administrator indicated she had no policy regarding diet orders.		**what corrective action(s) will be taken;** All residents have the potential to be affected by the cited practice. A full house audit was completed to ensure all residents had a current diet order. Any discrepancies were immediately corrected. III. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** Nurse will be educated on obtaining diet orders on all new admissions and entering them into PCC. 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;** DON/designee will audit all new admission to ensure diet orders are present. Audits will be completed weekly x 3 months, then monthly.The results of these audits will be reviewed by the RNC monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The RNC will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	

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R 0300 Bldg. 00	410 IAC 16.2-5-6(c)(4) Pharmaceutical Services - Deficiency (4) Over-the-counter medications, prescription drugs, and biologicals used in the facility must be labeled in accordance with currently accepted professional principles and include the appropriate accessory and cautionary instructions and the expiration date. Based on observation, interview, and record review, the facility failed to ensure medications were stored safely for 1 of 1 medication carts. Finding includes: During a medication cart observation, on 4/5/2023 at 2:38 P.M., with LPN 7, the following was observed: a disinfectant spray container was stored in the same area as resident medications. There was 3 opened and undated containers of a powder laxative for 3 different residents. During an interview, on 4/5/2023 at 2:40 P.M., LPN 7 indicated she did not know what the disinfectant container was used for/or why it was in the medication cart and the containers should have had opened dates on them. On 4/6/2023 at 11:30 A.M., the Administrator provided the policy titled,"Guidelines for the Storing of Medications", dated 2015. The policy indicated "...5. Antiseptics, disinfectants and germicides used in resident care must have legible, distinctive labels that identify the contents and the direction for use. These are to be stored separately from the regular medications...."	R 0300	I. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** The laxative containers were removed from the med cart and new containers were ordered from pharmacy. The new containers were dated when opened. The disinfectant was removed from the med cart. No residents had any adverse outcomes related to the cited practice. II. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** Any resident who receives medication has the potential to be affected by the cited practice. A med cart audit was completed to ensure all containers were dated when opened, and medications were stored properly. III. **What measures will be**	05/12/2023

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			put into place and what systemic changes will be made to ensure that the deficient practice does not recur; Nurses/QMAs were educated on the proper procedure for dating containers of medications when they are opened. They were also educated on the proper storage of medications. 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;** DON/designee will audit the medication cart to ensure meds containers are dated and medications are stored properly. These audits will be completed weekly x 3 months, then monthly. The results of these audits will be reviewed by the RNC monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The RNC will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	
R 0349 Bldg. 00	410 IAC 16.2-5-8.1(a)(1-4) Clinical Records - Noncompliance (a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that			

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	responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized. Based on record review and interview, the facility failed to ensure a resident had a physician order in place to self administer medications for 1 of 5 residents reviewed for clinical record's. (Resident B) Finding includes: During an interview, on 4/5/2023 at 10:38 A.M., Resident B indicated he administered his medications independently, except the narcotic pain medication he was prescribed. "The nurses gives me that pill." A record review was completed on 4/6/2023 at 10:16 A.M. Resident B's diagnoses included, anxiety, hypertension, depression, PTSD (post traumatic stress disorder), and Parkinson's disease. Current Physician's Orders for Resident B lacked an order to self administer medications. During an interview, on 4/6/2023 at 3:28 P.M., the Administrator indicated there should have been an order to self administer his medications. On 4/6/2023 a policy was requested for Physician Orders, but one was not provided prior to the survey exit.	R 0349	I. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** An order was obtained for resident B to self-administer medication. Resident B had no adverse outcomes related to the cited practice. II. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** All residents have the potential to be affected by the cited practice. A full house audit was completed to ensure any resident who is deemed safe to self-administer medications has an order in place to do so. III. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** Nurses were educated on procedure for obtaining an order for medication self-administration on any resident who is deemed safe	05/12/2023

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			to do so. 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;** DON/designee to audit med self-administration assessments to ensure any resident who is deemed safe to self-administer has an order in place. These audits will be completed weekly x 3 months, the monthly. The results of these audits will be reviewed by the RNC monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The RNC will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	
R 0406 Bldg. 00	410 IAC 16.2-5-12(a) Infection Control - Offense (a) The facility must establish and maintain an infection control practice designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of diseases and infection. Based on observation, interview, and record review, the facility failed to ensure infection control practices were followed during an insulin injection for 1 of 1 medication observations. (Resident 9) Finding includes:	R 0406	I. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident 9 had no adverse outcomes related to the cited	05/12/2023

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	During a medication administration on 4/5/2023 at 11:15 A.M., LPN 7 was observed to enter Resident 9's room. The LPN informed the resident she was going to administer insulin. . LPN 7 moved the sleeve to the left upper arm and injected the insulin into the residents' arm. LPN 7 did not clean the injection site prior to administering the injection, and did not wear gloves to administer the injection. During an interview, on 4/5/2023 at 11:26 A.M., LPN 7 indicated she should have disinfected the area prior to giving the injection and wore gloves. On 4/5/2023 a policy for administering injections was requested but one was not provided upon survey exit.		practice. II. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** Any resident who receives insulin has the potential to be affected by the cited deficient practice. LPN 7 was educated on the correct procedure for administering insulin injections. III. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** Nurses educated on proper procedure for giving an insulin injection. 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;** DON/designee to observe nurses administering an insulin injection weekly x 3 months then monthly. The results of these audits will be reviewed by the RNC monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The RNC will identify any trends or patterns	

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			and make recommendations to revise the plan of correction as indicated.	