STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155702	A. Building B. Wing	01/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aperion Care Peru	1850 West Matador St Peru, IN 46970

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to maintain a safe and sanitary environment in resident rooms and resident areas for three of four halls. (100 Hall, 200 Hall and 400 Hall)Finding includes:During the initial observations of residents, conducted between 1/25/2025 at 11:04 A.M. through /27/2025 at 2:30 P.M, the following observations were made:-In room [ROOM NUMBER], the inside of the door was missing paint in numerous areas.-In room [ROOM NUMBER], the inside of door had paint scraped off in several places.-In room [ROOM NUMBER], the door had multiple scrapes without paint and the wall next to the resident's bed was dirty. -In room [ROOM NUMBER], the bathroom ceiling vent above the shower had a heavy build-up of dust and there was blue masking tape wrapped around the smoke alarm.-In room [ROOM NUMBER], the wall surrounding the window was buckled and cracked. -In room [ROOM NUMBER], there were three holes behind the bed.-In room [ROOM NUMBER], the window well above the window had black spots, the windowsill had a heavy buildup of debris and the wall above the window was buckled. -In room [ROOM NUMBER], the blinds were broken and had missing sections.-In room [ROOM NUMBER], there was writing on the north wall, on the closet door and the blinds hanging in the window were bent or missing sections.-In room [ROOM NUMBER], the closet door was missing paint in some areas.-in room [ROOM NUMBER], the door had a large gouge. During a facility tour, conducted on 1/30/2026 at 10:17 A.M. with the Regional Nurse Consultant, the Housekeeping Supervisor (HS) and the Maintenance Director (MD) the following was observed:In room [ROOM NUMBER], the inside of the door was missing paint in numerous areas.-In room [ROOM NUMBER], the inside of door had paint scraped off in several places.-In room [ROOM NUMBER], the door had multiple scrapes without paint and the wall next to the resident's bed was dirty. -In room [ROOM NUMBER], the bathroom ceiling vent above the shower had a heavy build-up of dust and there was blue masking tape wrapped around the smoke alarm.-In room [ROOM NUMBER], the wall surrounding window is buckled and cracked. -In room [ROOM NUMBER], there were three holes behind the bed.-In room [ROOM NUMBER], the window well above the window had black spots, the windowsill had a heavy buildup of debris and the wall above the window was buckled. -In room [ROOM NUMBER], the blinds were broken and had missing sections.-In room [ROOM NUMBER], there was writing on north wall, on the closet door and the blinds hanging in the window had bent or missing sections.-In room [ROOM NUMBER], the closet door was missing paint in some areas.-In room [ROOM NUMBER], the door had a large gouge. During an interview with the Maintenance Director, on 1/30/2026 at 10:35 A.M., he indicated he completed daily walk throughs of the facility to identify repairs that were urgent. He indicated if he identified urgent repairs as anything that could affect resident safety, for example, blown light bulbs or exposed wiring. He indicated he utilized paper work orders submitted by staff to take care of routine repairs. The MD indicated he was the only full time employee for maintaining the building and did receive some help when he needed it. The MD indicated the walls that were buckled and cracked were due to a roof issue and he was not able to address the dry wall because he would have to move the resident's who currently occupied the rooms. The MD indicated there were open rooms at the time of (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	the facility walk-through. He indicated the rooms and doors with unpainted scrapes and gouges were on his list of to-dos, but he had not been able to address all of the rooms yet. He indicated the room with writing on the wall was from a previous resident, who had been moved to another room, and the room was on his list to repaint. He indicated he planned to replace the blinds in the rooms that had broken blinds. In room [ROOM NUMBER], the blue masking tape covering the smoke detector had been like that since 12/2/2025 when a local pest company treated the room for bed bugs. During an interview with the HS on 1/20/2026 at 10:40 A.M. she indicated the walls, window sills and vents were the responsibility of housekeeping. She confirmed room [ROOM NUMBER]'s wall were dirty, room [ROOM NUMBER]'s ceiling vent was covered in dust and the window sill and window well was dirty in room [ROOM NUMBER]. 2. During an observation on 1/29/2026 at 9:15 A.M., the pole used for Resident 40's gastrostomy tube (g-tube) feeding (a tube surgically placed directly into the stomach to provide nutrition via liquid formulas) had tube feeding formula dripped down the pole and on the base of the pole.During an interview on 1/29/2026 at 11:10 A.M. the DON indicated the pole for the tube feeding should have been clean. During an interview on 1/30/2026 at 10:27 A.M. the Housekeeping Supervisor indicated it was housekeeping's responsibility to clean the tube feeding pole. On 1/29/2026 at 12:15 P.M., the ED provided a policy, dated 1/25/20218 and titled, Cleaning & Sanitizing-Wheelchairs and Other Medical Equipment. The policy indicated, .Medical equipment/devices will be cleaned and sanitized weekly or more often if needed On 1/30/2025 at 11:59 A.M., the Executive Director provided undated document titled, Resident Room Daily Cleaning Check Off Sheet, and identified it as the check off sheet currently used by the facility. The check off sheet included: dust windowsill and scrub if needed, spot wash the walls and ensure all cobwebs, dust and debris are removed.On 1/30/2025 at 11:59 A.M., the Executive Director provided an undated policy titled, Housekeeping Guidelines, and identified the policy as the one currently used by the facility. The policy indicated, .6. Housekeeping personnel shall adhere to daily cleaning assignments developed so to maintain the facility in a clean and orderly manner On 1/30/2026 at 11:59 A.M., the Executive Director provided an undated policy titled, Environmental Services Policy, and identified it as the policy currently used by the facility. The policy indicated, .To ensure that the facility is designed, equipped and maintained in accordance with all governing rules and regulations and standards 3.1-19 (f)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview and record review, the facility failed to ensure medications were secure on 2 of 4 carts observed and in 1 of 16 resident rooms) (Wound Cart, South Treatment Cart and Resident 14's room) Findings include: 1. During an observation on 1/25/2026 at 10:55 P.M., the South Treatment Cart was unlocked and had medicated ointments, powders and sharp supplies, such as needles and scissors noted in the cart. During an interview on 1/25/2026 at 11:01 A.M., Licensed Practical Nurse (LPN) 2 indicated the Treatment Cart was unlocked. 2. During an observation 1/27/2025 at 9:45 A.M., the Wound Treatment Cart was unlocked and contained medicated ointments, powders and sharp supplies, such as needles and scissors in the cart. During an interview on 1/27/2025 at 9:50 A.M., Registered Nurse 3 indicated she had been responsible for the Wound Treatment Cart and the cart was not locked. 3. Upon entering the room of resident 14 on 1/25/2026 at 11:08 A.M , a medication cup with 10 pills was observed on the bedside tray. During an interview with the Director of Nursing on 1/25/2026 at 11:25 A.M., she indicated the pills shoul'sd not have been left at the bedside. She disposed of the pills in a biohazard container. During an observation and interview, conducted on 1/25/2026 at 11:30 A.M , LPN 3 entered Resident 14 room. She indicated she had forgotten to make sure the resident took her medications before she had left the room. On 1/20/2026 the Administrator provided a policy, Medication Administration General Guidelines. She indicated this is their current policy. Under section Administration 3. When medications are administered by mobile cart taken to the residence location (room, dining area, etc.) medications are administered at the time they are prepared. 16. The resident is always observed after administration to ensure the dose was completely ingested. 3.1-25(m)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation and interview, the facility failed to ensure a resident's right to communicate with staff providing services was protected for 1 of 3 residents reviewed for Resident's rights. (Resident 36)Finding includes:During an interview and observation on 1/27/2026 at 11:01 A.M., Resident 36 indicated, There he is ., and further stated he is a great guy when Employee 6 arrived to deliver the resident's clean laundry. However, Employee 6 did not acknowledge Resident 36 after the resident made the statements nor did the employee attempt to communicate with the resident. When Employee 6 was putting the Resident 36's clothes in his closet, the resident again indicated, There is my guy and attempted to engage the employee with conversation, but Employee 6 never acknowledged the resident before he put away the resident's clean laundry and left the room. During an interview on 1/27/2026 at 11:03 A.M., Employee 6 was asked if he could answer a few questions but he walked away without responding. Employee 6 was wearing a pink colored earbud in both of his ears. During an interview on 1/27/2026 at 11:07 A.M., the Housekeeping Supervisor (HS) indicated the Housekeeping Aides (HA) were permitted to wear one earbud at a time so that if someone was speaking to the HA, the HA would be able to hear what was being said. The HS indicated Employee 6 should have acknowledged Resident 36's attempt to talk to him. Resident 36's record review was completed on 1/28/2025 at 10:05 A.M. Diagnoses included, but were not limited to: dementia, generalized anxiety disorder and muscle atrophy. A Quarterly Minimum Data Set (MDS) assessment dated , 1/4/2026 indicated Resident 36 had clear speech, had been able to make himself understood, had significant cognitive impairment and had not had any behaviors or rejection of care. During an interview with the Executive Director on 1/28/2026 at 2:26 P.M., the ED indicated the facility did not have a policy related to the use of earbuds while working, but the facility allowed the staff to wear one earbud, in either ear, but not two earbuds. 3.1-3 (a)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on observation, record review, and interview, the facility failed to notify the physician of a significant weight loss for 1 of 1 resident reviewed for nutrition. Findings include:The clinical record for Resident 52 was reviewed on 1/28/2026 at 10:34 A.M. Diagnoses included but were not limited to: Alzheimer's disease, chronic obstructive pulmonary disease, asthma, anxiety and dementia. The most recent Minimum Data Set (MDS) assessment, completed as a quarterly review, on 12/1/2025 indicated the resident was severely cognitively impaired and required supervision for eating needs. Nursing Progress notes indicated on 12/3/2025, the resident weighed 108.5 pounds. On 1/6/2026, the resident weighed 104.5 pounds a -3.69% loss in one month.On 1/6/2026, the resident weighed 104.5 pounds, on 1/30/2026, the resident weighed 99 pounds a -5.26% loss in less than a month. There was no documentation the physician had been notified of the significant weight loss.On 8/5/2025, the resident weighed 117 pounds, on 1/30/2026, the resident weighed 99 pounds a -15.38% loss in less than 6 months. There was no documentation the physician had been notified of the significant weight loss.Resident 52 was observed, on 01/25/2026 at 10:40 AM walking around the nursing unit. She appeared thin, her skin was dry and flaky, her clothes were loose, baggy and did not fit.During an interview with the Assistant Director of Nursing (ADON), on 1/30/2026, she indicated she was responsible for overseeing the monitoring of residents' weights. She indicated she was not aware that a 5% weight loss in one month or a 10% weight loss in 6 months required the facility to notify the physician.On 1/30/2026 at 12:18 p.m., the Administrator, provided a policy, dated 11/14/2012, titled Weights, and indicated it was the policy currently being used by the facility. The policy indicated, 6. Undesired or unanticipated weight gains/loss of 5% in 30 days, 7.5% in three months, or 10% in six months shall be reported to the physician, dietician and/or dietary manager as appropriate.3.1-5 (a)(2)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on interview and record review, the facility failed to ensure a person-centered comprehensive care plan was updated for a resident with a significant weight loss for 1 of 1 residents reviewed for nutrition. (Resident 52)Findings include:The record for Resident 52 was reviewed on 1/28/2026 at 10:34 A.m. Diagnoses included, but were not limited to: Alzheimer's disease, chronic obstructive pulmonary disease, asthma, anxiety and dementia. The most recent Minimum Data Set (MDS) assessment, completed as a quarterly review on 12/1/2025, indicated Resident 52 had severe cognitive impairment, required supervision for eating needs and was a smoker. Resident 52 was observed, on 01/25/2026 at 10:40 AM, walking around the unit. She was thin, her skin was dry and flaky and her clothes did not fit and were loose and baggy.A current care plan, initiated on 12/10/2024, indicated the following problem: I have an unplanned/unexpected weight gain related to improved intake.(sic) The goal for the plan was . The interventions included. The plan indicated it had been reviewed on 12/9/2025 but there were no interventions to address the resident's weight loss and the problem was not revised to reflect the resident's current nutritional status or the development of continued significant weight loss.3.1-35(c)(1)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observation, interview and record review, the facility failed to provide showers or bed baths for a dependent resident for 1 of 4 residents who were reviewed for Activities of Daily Living needs. (Resident 3)Finding includes: During an observation on 1/25/2026 at 12:08 P.M., Resident 3's hair was sticking up and was unbrushed. During an interview on 1/25/2026 at 1:59 P.M., Resident 3's right hand was sticky and she was unable to recall the last time she had had a shower. Resident 3's record review was completed on 1/28/2025 at 10:30 A.M. Diagnoses included but were not limited to: schizophrenia, epilepsy, major depressive disorder, dementia with moderate behavioral disturbances and generalized anxiety disorder. A Quarterly Minimum Data Set (MDS) assessment, dated 1/9/2025, indicated Resident 3 had clear speech, usually made herself understood and had been able to understand others, had severe cognitive impairment, had had no behaviors and had not rejected care and was dependent on staff for all transfers and for showering or bed baths needs. Resident 3's January showers were reviewed and indicated the resident was to receive a shower or bed bath on Tuesdays and Fridays. Resident 3's record lacked the documentation that the resident had been showered or had received a bed bath on 1/2, 1/6 or 1/9/2026. A current Care Plan, initiated on 11/21/2023, indicated Resident 3 required assistance with activities of daily living. A current intervention, initiated on 11/21/2023, indicated Resident 3 received showers and her usual performance for showers was dependent on staff. During an interview on 1/29/2025 at 9:45 A.M., CNA 5 indicated the facility charted showers or bed baths in the record and if the resident refused the shower, the refusal was documented in the record. CNA 5 indicated there was no other place in the record where showers or bed baths were charted. During an interview on 1/30/2025 at 9:00 A.M., the Director of Nursing (DON) indicated there had not been any documentation Resident 3 had received a shower or bed bath on 1/2, 1/6 or 1/9/2026 or any documentation the resident had refused a shower or bed bath for the month of January 2026 in her record. On 1/29/2025 at 2:45 P.M., the Executive Director (ED) provided a policy dated, 11/28/2012, and titled, Bathing, Showering and Tub Bath. The ED indicated the policy was the one currently used by the facility. The policy indicated, . A shower, tub bath or bed/sponge bath will be offered according to resident's preference two times per week or according to the resident's preferred frequency and as needed or requested 3.1-39(a)(3)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on observation, record review and interview, the facility failed to implement physician recommendations in a timely manner after a fall with injury for 1 of 1 resident reviewed for falls. (Resident 5)Finding includes:During an interview, on 1/27/2026 at 2:23 P.M., Resident 5 indicated he had a recent fall and had elbow pain.During an interview and observation, on 1/29/2026 at 8:51 A.M., Resident 5 indicated his elbow painful and there was obvious swelling around the elbow. In addition he wore a compression stocking on his right arm.During an observation, on 1/30/2026 at 9:15 A.M., Resident 5 was observed to have purple and red bruising below and above the left elbow.A record review for Resident 5 was completed on 1/28/2026 at 9:15 A.M. Diagnoses included, but were not limited to: neuropathy, gout, peripheral vascular disease, diabetes mellitus type 2 and schizoaffective disorder.A Quarterly Minimum Data Set (MDS) assessment, dated 12/3/2025, indicated Resident 5 had moderate cognitive impairment and required supervision for transfers. A Nursing Progress Note, on 1/25/2026 at 11:51 P.M., indicated Resident 5 had been observed at 11:11 P.M. walking from his room to the dining room to watch television with a friend. Resident 5 had been observed to stagger backwards and had fallen on his back.A Nursing Progress Note, on 1/26/2026 9:49 A.M., indicated Resident 5 had fallen earlier and a new order had been obtained for a left elbow x-ray due to swelling. In addition, an order to hold his prescribed Eliquis (blood thinner) for five days was received.A Physician Note, on 1/26/2026 at 11:23 A.M., indicated Resident 5 had fallen and had a swollen left elbow. Resident 5 was also documented to have pain to the left elbow. New orders for Voltaren gel (Diclofenac Sodium External Gel, a nonsteroidal anti-inflammatory drug), ice (to the left elbow) , x-ray and holding Eliquis were prescribed.Although the physician note included treatment orders, the orders were not documented and implemented timely in the clinical record.A Nursing Progress Note, on 1/28/2026 at 10:24 A.M., indicated Resident 5 had edema and discoloration to the left elbow and voiced discomfort to the left elbow.A Physician's Order, dated 1/28/2026, indicated Diclofenac Sodium External Gel 1 %, apply gel to the left elbow every eight hours as needed.A Physician's Order, dated 1/28/2026, indicated to hold Eliquis 5 milligrams twice daily for five days. The medication began being held on 1/28/2026 for the evening dose.A Care Plan, initiated on 3/20/2021 and revised on 1/27/2026, indicated Resident 5 was on an anticoagulant and the Eliquis was to be held for five days. During an interview, on 1/30/2026 at 9:28 A.M., the Director of Nursing indicated the Eliquis should have been stopped right away on 1/26/2026 and an order for the ice treatment to the elbow should have been written. A current policy was provided by the Executive Director, on 1/20/2026 at 12:11 P.M. The policy titled, Physician Orders-Entering and Processing, indicated, .To provide general guidelines when receiving, entering, and confirming physician or prescriber's orders.5. Following a physician visit, a licensed nurse will check for any orders that require confirmation.The orders will be confirmed by the nurse and the instructions for the order will be completed.3.1-37(a)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. Based on observation, record review, and interview, the facility failed to complete a timely nutritional assessment and initiate interventions to prevent weight loss for 1 of 1 residents reviewed for nutrition. (Resident 52) This resulted in continued significant weight loss of 15.38% over the previous 5 months. Findings include:The clinical record for Resident 52 was reviewed on 1/28/2026 at 10:34 A.M. Diagnoses included but were not limited to: Alzheimer's disease, chronic obstructive pulmonary disease, asthma, anxiety and dementia. The most recent Minimum Data Set (MDS) assessment, completed for a quarterly review, on 12/1/2025, indicated the resident was severely cognitively impaired, required supervision for eating needs and was a smoker. Resident 52 was observed, on 01/25/2026 at 10:40 AM walking around the nursing unit. She was thin, her skin was dry and flaky, her clothes were loose, baggy and did not fit her. A care plan dated 12/10/2024, indicated I have a nutritional problem or potential nutritional problems related to Alzheimer's disease, anxiety, chronic obstructive pulmonary disease, depression, etc The Goal indicated the following: I will consume 50/100% of two of three meals a day. Interventions included: Monitor and record food intake at each meal.Physician orders indicated the resident was to receive a regular diet with regular texture and consistency. Physician orders on 1/22/2026 added an intervention to provide a nutritional house supplement twice a day.Nursing progress notes documented the following weights for Resident 52: 8/5/2025, the resident weighed 117 pounds9/5/2025 , the resident weighed 115 pounds10/2/2025, the resident weighed 114 pounds11/6/2025, the resident weighed 112 pounds12/3/2025, the resident weighed 108.5 pounds1/6/2026, the resident weighed 104.5 pounds - a 9% weight loss in the past 90 days1/30/2026, the resident weighed 99 pounds - 5.25% weight loss in the past 30 days and 15.38% weight loss since August 2025 A nutritional assessment was completed by a registered dietician on 4/25/2025 but did not reflect any concerns with the resident's weight at the time it was completed. There were no other nutritional assessments completed by the dietician until 1/22/2026. The assessment completed on 1/22/2026 indicated the following: A 9% weight loss in 90 days, Body Mass Index (BMI) was 21.1, within normal limits. May suggest a house nutritional supplement to be given twice daily to help increase calories and a protein. The assessment occurred 16 days after the nutritional consultation had been requested. During an interview with a Registered Dietician supervisor, on 1/30/2026 11:40 A.M., she indicated the nutritional assessment should have been completed within 72 hours after receiving the resident's weight (which indicated the resident had experienced a significant weight loss) from the facility on 1/6/2026. In addition, she indicated the intervention of nutritional supplement shakes were meant to prevent weight loss, not treat the weight loss.During an interview with Assistant Director of Nursing, on 1/30/2026, she indicated she was responsible for overseeing and monitoring residents' weights. She indicated she was not aware that a 5% weight loss in one month, a 7.5% weight loss in 90 days or a 10% weight loss in 6 months required notifying a physician or dietician.On 1/30/2026 at 12:18 p.m., the Administrator, provided a policy, dated 11/14/2012, titled Weights, and indicated it was the policy currently being used by the facility. The policy indicated, 6. Undesired or unanticipated weight gains/loss of 5% in 30 days, 7.5% in three months, or 10% in six months shall be reported to the physician, dietician and/or dietary manager as appropriate.3.1-46(a)(1)

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. Based on record review and interview, the facility failed to obtain ordered laboratory orders for 1 of 5 residents reviewed for unnecessary medications. (Resident 1)Finding includes:A record review for resident 1 was completed on 1/28/2026 at 10:00 A.M. Diagnoses included, but were not limited to: bipolar disorder, hepatitis C, diabetes mellitus and history of alcohol use. A Quarterly Minimum Data Set (MDs) assessment, dated 12/18/2025, indicated Resident 1 had severe cognitive impairment and was administered medication of an antipsychotic, antidepressant, opioid and anticonvulsant.A Physician's Order, dated 11/18/2024, indicated laboratory orders for a prealbumin, vitamin D, vitamin B12 and folate level annually in October. However, these laboratory values, due in October 2025, could not be located in the medical record, nor provided by the laboratory facility.During an interview, on 1/30/2026 at 9:02 A.M., LPN 3 indicted the ordered laboratory values could not be located and the laboratory orders should have been drawn.A current policy was provided by the Executive Director, on 1/20/2026 at 12:11 P.M. The policy titled, Physician Notification of Laboratory/Radiology/Diagnostic Results, indicated, .To assure physician ordered diagnostic test are preformed, and to assure test results are reported to the physician so that prompt, appropriate action can be taken if indicted for the resident's care.A licensed nurse is responsible for assuring the laboratory is notified of physician's orders for testing.A nurse is responsible for monitoring the receipt of test results.3.1-49(a)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155702	A. Building B. Wing	01/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aperion Care Peru	1850 West Matador St Peru, IN 46970

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. Based on interview and record review, the facility failed to complete dental recommendations from the in-house dentist for 1 of 1 resident reviewed for dental care. (Resident 77) Finding includes:During an interview, on 1/25/2026 at 1:59 P.M. Resident 77 indicated he had mouth pain due to something messing with his teeth. He indicated, I have some cavities.A record review for Resident 77 was completed on 1/28/2026 at 1:05 P.M. Diagnoses included, but were not limited to: diabetes mellitus type 2, dementia and obstructive sleep apnea.A Quarterly Minimum Data Set (MDS) assessment, dated 12/3/2025, indicated Resident 77 had severe cognitive impairment and had no dental issues.A Physician's Order, dated 1/2/2025, indicated dental care as needed.A Dental Consult Note, dated 12/8/2025, indicated Resident 77 had upper right mouth pain sometimes and lower left nerve pain if his tongue touched his teeth. Resident 77 also had a draining fistula between teeth number 20 and 21 (lower left bicuspids). An outside referral for full mouth extraction was made.A Dental Hygienist Encounter Form, dated 12/10/2025, indicated Resident 77 had pain in his mouth and would not allow brushing, but a soft sponge moistened with mouthwash to remove some plaque. The note indicated Resident 77 was awaiting an appointment for full mouth extraction. A Care Plan, initiated on 11/24/2021 and revised on 10/1/2025, indicated Resident 77 had oral/dental health problems related to requiring assistance with oral care. The goal was to be free of infection, pain or bleeding in the oral cavity. Interventions included, but were not limited to: coordinate arrangements for dental care, transportation as needed or ordered and monitor/document/report as needed any signs or symptoms of oral/dental problems needing attention as pain, abscess or debris in the mouth.During an interview, on 1/30/2026 at 9:30 A.M., the Director of Nursing indicated for dental appointments an order should have been obtained and the transportation director would have made the appointment.During an interview, on 1/30/2026 at 10:28 A.M., the transportation director indicated she scheduled all outside appointments. She indicated an outside dental appointment for extraction had not been set up for Resident 77. She indicated no one at the facility had informed her of the need for an outside dental appointment for Resident 77.A current policy was provided by the Executive Director, on 1/20/2026 at 12:11 P.M. The policy titled, Dental Services and Loss or Damage of Dentures, indicated, .The facility will, if necessary or requested by the resident, assist with scheduling appointments for dental services, arranging for transportation to and from the dental service location and promptly refer residents with lost or damaged dentures for dental services.If a referral does not occur in 3 days, the facility will implement interventions and document these interventions to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay.3.1-24(a)(3)