STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155208	A. Building B. Wing	04/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aperion Care Hanover	410 W Lagrange Rd Hanover, IN 47243

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, and interview, the facility failed to implement fall interventions for 3 of 4 residents reviewed for Implementation of Care Plans. (Residents 6, 12, and 20)Findings include: 1. Resident 6's clinical record was reviewed on 04/13/2026 at 2:32 P.M. A Significant Change Minimum Data Set (MDS) assessment, dated 02/08/2026, indicated the resident was moderately cognitively impaired. The resident's diagnoses included, but were not limited to, a fracture of the first cervical vertebra (a bone that forms the neck region of the spine), stroke (a medical emergency that occurs when blood flow to part of the brain is blocked that can cause neurological deficits), and repeated falls. The resident's range of motion in one of his arms was impaired and he used a wheelchair. The resident experienced a fall without injury and a fall with a major injury since the last assessment. The resident's Risk for Falls Care Plan was initiated on 09/05/2025, and included but was not limited to, to following interventions: - An intervention, initiated on 10/17/2025, to place Call, Do Not Fall signage in the resident's room. The resident was observed in bed in his room on 04/09/2026 at 11:12 A.M. The resident was wearing a neck brace and a splint on his right hand. There were no signs posted in the resident's room. During an observation, on 04/13/2026 at 10:27 A.M., the resident was in his room in bed. There were no signs posted in the resident's room. During an observation, on 04/13/2026 at 1:45 P.M., the resident was in his room in bed. There were no signs posted in the resident's room. During an interview, on 04/14/2026 at 10:04 A.M., Licensed Practical Nurse (LPN) 3 indicated she was familiar with the resident. He had experienced several falls. He had fractured a bone in his neck and a bone in his right hand when he fell in February and fractured his left hip after a fall less than two weeks ago. When asked why she thought he fell so frequently, the LPN indicated the resident often forgot to use his call light. He doesn't realize he is getting weaker and forgets to use his call light. During an observation with LPN 3, on 04/14/2026 at 10:05 A.M., the resident was in his room in bed. LPN 3 looked around and indicated there were no signs posted in the resident's room. During an observation on 04/14/2026 at 2:14 P.M., the resident was in his room in bed. There were no signs posted in the resident's room. During an observation on 04/15/2026 at 10:23 A.M., the resident was in his room in bed. There were no signs posted in the resident's room. (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2.During an observation, on 04/13/2026 at 11:45 A.M., Resident 12 was sitting at a table in the Wing 2 Dining Room. The resident stood up from his wheelchair and walked to the nurse's station and asked for a drink/snack. Licensed Practical Nurse 4 assisted the resident back to his wheelchair. There were no alarms in place to the resident's wheelchair. During an observation and interview, on 04/13/2026 at 12:13 P.M., Resident 12 was sitting in the Wing 2 Dining Room in his wheelchair. There was no chair alarm present. CNA 8 indicated the resident had a few falls recently. He had a pressure alarm to his bed. The resident liked to get up and run around. They usually had to ask him to sit back down because that was when he would fall. The resident's interventions for falls were placed on the pocket sheets that the C NAs carried on them every day. She thought the resident's chair alarm was discontinued when he went from a Broda chair to a regular wheelchair. During an interview and record review, on 04/13/2026 at 12:27 P.M., CNA 8 indicated and showed that the resident had an intervention on the pocket sheet for a chair alarm. The resident didn't have a chair alarm in place at that time, and she would have to go dig it out of the room as she was unsure where it was located. The clinical record for Resident 12 was reviewed on 04/14/2026 at 9:47 A.M. A Quarterly MDS assessment, dated 03/21/2026, indicated the resident was severely cognitively impaired. The resident's diagnoses included, but were not limited to, Huntington's (neurodegenerative disorder) disease and other fracture. The resident had falls prior to the assessment. An open-ended physician's order, with start date of 11/17/2025, indicated the resident was to have a Chair Pressure Alarm (CPA), at all times for safety. 3. The clinical record for Resident 20 was reviewed on 04/13/2026 at 2:20 P.M. A Quarterly MDS assessment, dated 01/05/2026, indicated the resident was cognitively intact. The resident's diagnoses included, but were not limited to, rib fractures, dementia, seizure disorder, anxiety, repeated falls, and insomnia. The resident had two or more falls since the last assessment with no injury, and two or more falls since the last assessment with minor injuries. The previous assessment was a Significant Change MDS assessment dated [DATE]. The resident's Risk for Falls Care Plan indicated they had poor balance and an unsteady gait. Interventions included, but were not limited to, the following: -Signage placed in several places in resident's room stating, Call for help do not fall, initiated on 04/06/2024, and -Colored tape to the resident's walker, initiated on 10/12/2025. During an observation and interview, on 04/10/2026 at 1:37 P.M., Resident 20 was sitting in her recliner in her room. The backs of the resident's hands were bruised, and she had adhesive strips on her left hand. She was not sure how she had injured her hand. She had recently started on a new medication, and it made her kind of, woozy. She thought she may have injured them one day when she had been in her doorway and slid down the door frame. The resident had a walker next to her recliner. There were no signs posted in her room or colored tape on her walker. The resident indicated she did not use her walker to go to the bathroom because the bathroom was just next door to her room. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation, on 04/10/2026 at 2:57 P.M., there were no signs posted in the resident's room or colored tape on her walker. During an observation, on 04/13/2026 at 10:09 A.M., there were no signs posted in the resident's room or colored tape on her walker. The resident was sitting in her recliner. During an observation, on 04/13/2026 at 1:59 P.M., there were no signs posted in the resident's room or colored tape on her walker. The resident was sitting in her recliner. The Certified Nurse Aide (CNA) pocket sheet for Wing 1, the Dementia Unit, was provided by CNA 6 on 04/14/2026 at 9:43 A.M. CNA 6 indicated the pocket sheet was how she knew what the Care Plan interventions were for each resident. During an observation of Resident 20's room with CNA 6, on 04/14/2026 at 9:46 A.M., the CNA indicated she had no idea about the signs, but a staff member had put bright tape on the resident's walker at one time. The CNA asked the resident if she had taken the bright tape off her walker and the resident indicated, No. There were no signs posted in the room and there was no colored tape on the resident's walker. The current Fall Prevention Program policy, with an effective date of 11/28/2012, was provided by ##. The policy indicated, .The Fall Prevention Program includes .Care plan incorporates .Addresses each fall .Interventions are changed with each fall, as appropriate .Preventative measures . 410 IAC (Indiana Administrative Code) 16.2-3.1-35(g)(2)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on record review and interview, the facility failed to follow physician's orders related to hold parameters for medications and follow manufacturer's guidelines for administering insulin for 3 of 21 residents reviewed for Quality of Care. (Residents 20, 14, and 67) Findings include:1.The clinical record for Resident 20 was reviewed on 04/13/2026 at 2:20 P.M. A Quarterly Minimum Data Set (MDS) assessment, dated 01/05/2026, indicated the resident was cognitively intact. The resident's diagnosis included, but was not limited to, hypertension. A current physician's order, with a start date of 11/24/2025, indicated the resident was to receive Carvedilol, a cardiac medication, 3.125 milligrams (mg) two times a day for hypertension. The medication was to be held, not given, if the systolic blood pressure (the top number, measures the maximum pressure in your arteries when your heart contracts and pumps blood) was less than 120. The resident's April 2026 Electronic Medication Administration Record (EMAR) was reviewed and indicated the resident had received the medication when the resident's systolic blood pressure was less than 120 on the following dates and times: - On 04/02/2026 at 7:00 A.M., when the resident's systolic blood pressure was 112, the resident received the Carvedilol medication. - On 04/02/2026 at 7:00 P.M., when the resident's systolic blood pressure was 118, the resident received the Carvedilol medication. - On 04/03/2026 at 7:00 A.M., when the resident's systolic blood pressure was 118, the resident received the Carvedilol medication. - On 04/04/2026 at 7:00 A.M., when the resident's systolic blood pressure was 112, the resident received the Carvedilol medication. - On 04/05/2026 at 7:00 A.M., when the resident's systolic blood pressure was 116, the resident received the Carvedilol medication. - On 04/06/2026 at 7:00 A.M., when the resident's systolic blood pressure was 110, the resident received the Carvedilol medication. - On 04/06/2026 at 7:00 P.M., when the resident's systolic blood pressure was 118, the resident received the Carvedilol medication. - On 04/07/2026 at 7:00 A.M., when the resident's systolic blood pressure was 116, the resident received the Carvedilol medication. - On 04/07/2026 at 7:00 P.M., when the resident's systolic blood pressure was 116, the resident received the Carvedilol medication. - On 04/09/2026 at 7:00 P.M., when the resident's systolic blood pressure was 118, the resident received the Carvedilol medication. - On 04/10/2026 at 7:00 P.M., when the resident's systolic blood pressure was 118, the resident (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	received the Carvedilol medication. - On 04/12/2026 at 7:00 A.M., when the resident's systolic blood pressure was 118, the resident received the Carvedilol medication. - On 04/13/2026 at 7:00 A.M., when the resident's systolic blood pressure was 118, the resident received the Carvedilol medication. - On 04/14/2026 at 7:00 P.M., when the resident's systolic blood pressure was 117, the resident received the Carvedilol medication. - On 04/15/2026 at 7:00 A.M., when the resident's systolic blood pressure was 112, the resident received the Carvedilol medication. - On 04/16/2026 at 7:00 A.M., when the resident's systolic blood pressure was 112, the resident received the Carvedilol medication. 2a. The clinical record for Resident 14 was reviewed on 04/13/2026 at 10:53 A.M. A Quarterly MDS assessment, dated 02/24/2026, indicated the resident was cognitively intact. The resident's diagnoses included, but were not limited to, heart failure (chronic, serious condition where the heart muscle cannot pump blood efficiently enough to meet the body's needs for oxygen and nutrients), hypertension, and diabetes. A physician's order, dated 01/19/2026 through 04/09/2026, indicated the resident was to receive Insulin Glargine, 12 units subcutaneously, twice a day. The medication was to be held of the resident's blood glucose level was less than 110. The February, March, and April 2026 EMAR was reviewed and indicated the resident had received the medication when the resident's blood glucose levels were less than 110 on the following dates and times: - On 02/08/2026 at 7:00 A.M., when the resident's blood glucose level was 70, the resident received the Glargine.- On 02/13/2026 at 7:00 A.M., when the resident's blood glucose level was 92, the resident received the Glargine.- On 02/16/2026 at 7:00 A.M., when the resident's blood glucose level was 65, the resident received the Glargine.- On 02/21/2026 at 7:00 A.M., when the resident's blood glucose level was 94, the resident received the Glargine.- On 02/22/2026 at 7:00 A.M., when the resident's blood glucose level was 62, the resident received the Glargine.- On 02/26/2026 at 7:00 A.M., when the resident's blood glucose level was 62, the resident received the Glargine. - On 03/04/2026 at 7:00 A.M., when the resident's blood glucose level was 104, the resident received the Glargine.- On 03/06/2026 at 7:00 A.M., when the resident's blood glucose level was 70, the resident received the Glargine.- On 03/07/2026 at 7:00 A.M., when the resident's blood glucose level was 89, the resident received the Glargine.- On 03/08/2026 at 7:00 A.M., when the resident's blood glucose level was 84, the resident received the Glargine.- On 03/11/2026 at 7:00 A.M., when the resident's blood glucose level was 68, the resident received the Glargine.- On 03/12/2026 at 7:00 A.M., when the resident's blood glucose level was 62. the resident received the Glargine.- On 03/17/2026 at 7:00 A.M., when the resident's blood glucose level was 105, the resident received the Glargine.- On 03/20/2026 at 7:00 A.M., when the resident's blood glucose level was 68, the resident received the Glargine.- On 03/22/2026 at 7:00 P.M., when the resident's blood glucose level was 109, the resident received the Glargine. - On 03/31/2026 at 7:00 A.M., when the resident's blood glucose level was 74, (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the resident received the Glargine. 2b. A physician's order, dated 11/25/2025 through 04/09/2026, indicated the resident was to receive Midodrine (medication used to treat symptomatic low blood pressures) 2.5 mg, three times a day. The staff were to hold the medication if the residents systolic blood pressure was greater than 130. The February, March, and April 2026 EMAR indicated the resident had received the medication when the residents systolic blood pressure was greater than 130 on the following dates and times: - On 02/04/2026 at 7:00 P.M., when the resident's systolic blood pressure was 143, the resident received the Midodrine medication. - On 02/09/2026 at 1:00 P.M., when the resident's systolic blood pressure was 143, the resident received the Midodrine medication. - On 02/10/2026 at 1:00 P.M., when the resident's systolic blood pressure was 144, the resident received the Midodrine medication. - On 02/14/2026 at 1:00 P.M., when the resident's systolic blood pressure was 146, the resident received the Midodrine medication. - On 02/21/2026 at 7:00 P.M., when the resident's systolic blood pressure was 139, the resident received the Midodrine medication. - On 02/22/2026 at 1:00 P.M., when the resident's systolic blood pressure was 131, the resident received the Midodrine medication. - On 02/25/2026 at 1:00 P.M., when the resident's systolic blood pressure was 131, the resident received the Midodrine medication. - On 03/07/2026 at 7:00 A.M., when the resident's systolic blood pressure was 133, the resident received the Midodrine medication. - On 03/16/2026 at 7:00 A.M., when the resident's systolic blood pressure was 131, the resident received the Midodrine medication. - On 03/26/2026 at 7:00 P.M., when the resident's systolic blood pressure was 144 the resident received the Midodrine medication. - On 04/03/2026 at 7:00 P.M., when the resident's systolic blood pressure was 136, the resident received the Midodrine medication. - On 04/04/2026 at 7:00 A.M., when the resident's systolic blood pressure was 132, the resident received the Midodrine medication. During an interview, on 04/13/2026 at 1:36 P.M., RN 2 indicated if a resident's medications had hold parameters, then she would obtain the resident's vital signs before giving the medication. If the vitals did not fall within the parameters of giving the medication, then she would not administer the medication and document it in a progress note that the medication was not given. During an interview, on 04/14/2026 at 2:53 P.M., the DON indicated if a medication had hold parameters, then the nurse would get the resident's vital signs and if they were outside the parameters then the medication would not have been administered. If the medication was not administered, then there would be a progress note and documentation in the EMAR as not given. The current, undated, facility policy titled, Medication Administration General Guidelines was provided by the Administrator on 04/14/2026 at 4:33 P.M. The policy indicated, .Medications are administered as prescribed in accordance with good nursing principles and practices. 3. During a medication administration observation, on 04/15/2026 at 11:50 A.M., Licensed Practical Nurse (LPN) 7 removed Resident 67's Fiasp insulin pen from the top drawer of the medication cart. She cleaned the hub of the pen, placed a needle on the end of the pen, turned the dial to 10 units, and walked to the resident's room. The nurse indicated she was unaware insulin pens needed to be primed, she had never been taught to prime the pens. The Fiasp insulin pen package insert was provided by the Director of Nursing on 04/15/2026 at 3:35 P.M. The steps for administering indicated, .Priming your FIASP .Pen .Turn the dose selector to select 2 units .Hold the Pen with the needle pointing up. Tap the top of the Pen gently a few times to let any (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	air bubbles rise to the top .Hold the Pen with the needle pointing up. Press and hold the dose button until the dose counter shows 0 .A drop of insulin should be seen at the needle tip . 410 IAC (Indiana Administrative Code) 16.2-3.1-37(a)

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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 and interview, the facility failed to store medications appropriately for 3 of 4 Medication Carts and 1 of 2 Medication Rooms reviewed. (Wing 4, Wing 3/Cart 3, Wing 2/Cart 1, and Wing 3 Medication Room). Findings include:1.On 04/09/2026 at 10:44 A.M., the Wing 4 Medication Cart was observed with RN 2, and contained the following: -A Novolog insulin pen, that was in the top drawer, for Resident 71 had 150 units of insulin left in it. The bag that the insulin pen was in had a written date of 03/05. The insulin pen had a number 3 written on it, with the rest of the numbers smeared and unreadable, -A full, undated, Insulin Glargine insulin pen, that was in the top drawer, for Resident 67. The RN indicated she had just opened the pen that morning, -An undated, Fiasp insulin pen, that was in the top drawer, for Resident 67 that had 50 units left in it, -A Humalog insulin pen, that was in the top drawer, for Resident 14 that was less than a 1/4 full and dated 03/07, and -In the second drawer there were two loose small oval pills and two loose small white round pills. The RN indicated insulin was good for 30 days once it was taken out of the refrigerator. 2. On 04/09/2026 at 10:59 A.M., the Wing 3/Cart 3 Medication Cart was observed with Licensed Practical Nurse (LPN) 3 and contained the following: -In the second drawer there was a loose small blue round pill, an oval pill, and a small round white pill. The nurse indicated the pills were Sinemet, Namenda, and Lasix, and -In the top, right drawer an unopened Lantus insulin pen for Resident 2, and an undated vial of Humulin insulin that had approximately 1/4 left in it for Resident 64. 3. On 04/09/2026 at 11:09 A.M., Wing 2/Cart 1 was observed with LPN 4, and contained the following: -A loose, unknown, small tan pill in the second drawer. During an interview, on 04/14/2026 at 2:53 P.M., the Director of Nursing (DON) indicated insulin was good for 30 days after it had been opened. Insulins should be dated when opened. If the insulin was unopened it should remain in the refrigerator. During an interview, on 04/16/2026 at 1:20 P.M., RN 5 indicated med carts should be clean, free of trash, and medications should not be loose in the drawers. The current, undated, facility policy titled, Storage of Medications was provided by the Administrator on 04/15/2026 at 12:32 P.M. The policy indicated, .Medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier.Outdated, contaminated, or deteriorated medications.are immediately removed from inventory, disposes of (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	according to procedures for medication disposal and reordered from the pharmacy, if a current order exists.Medication storage areas are kept clean, well-lit, and free of clutter. A Novolog Insert, with a revision date of 02/2023 was provided by the Administrator on 04/15/2026 at 1:17 P.M. The insert indicated, .Throw away all opened Novolog.after 28 days even if they still have insulin in them. A Lantus insert was provided by the Administrator on 04/15/2026 at 1:17 P.M. The insert indicated, .Not in-use (unopened) Room Temperature.28 days. A Fiasp insert was provided by the Administrator on 04/15/2026 at 1:17 P.M. The insert indicated, .Do not use.past the expiration date printed on the label or 28 days after you start using the pen. A Humalog insert was provided by the Administrator on 04/15/2026 at 1:17 P.M. The insert indicated, .Storage and Handling.In-use.Room Temperature.28 days. A Humulin insert was provided by the Administrator on 04/15/2026 at 1:17 P.M. The insert indicated, .Storage.In-Use.Opened.31 days. 4. The Wing 3 Medication Room was observed on 04/15/2026 at 11:40 A.M., with RN 5. A bottle of tuberculin serum that was half full, in a refrigerator lacked an opened date. There were two half dollar size spots of an unknown brownish substance on the bottom shelf and two quarter size spots of an unknown brownish substance on the top shelf of the medication refrigerator. RN 5 indicated the tuberculin serum should have had an opened date on the bottle. She had no idea what the brownish substance was, and the medication refrigerator should be kept clean. The tuberculin serum package directions for storage indicated, .vials in use more than 30 days should be discarded . The current, undated, facility policy titled, Storage of Medications was provided by the Administrator on 04/15/2026 at 12:32 P.M. The policy indicated, .Medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier.Outdated, contaminated, or deteriorated medications.are immediately removed from inventory, disposes of according to procedures for medication disposal and reordered from the pharmacy, if a current order exists.Medication storage areas are kept clean, well-lit, and free of clutter. 410 IAC (Indiana Administrative Code) 16.2-3.1-25(o)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. Based on observation, interview, and record review, the facility failed to assess a resident for self-administering medications for 1 of 18 residents observed for medications left at the bedside. (Resident 8) Findings included:During an observation and interview, on 04/09/2026 at 12:12 P.M., Resident 8 was sitting in his recliner in his room. His over-bed table was next to the recliner and contained several personal items, including, but not limited to, a white tube of ointment with a yellow label that had the cap on in a skewed manner, and a five cubic centimeter syringe of clear fluid. The resident indicated the tube of ointment was numbing cream he applied to his skin a couple hours before he left for dialysis treatments. The syringe was normal saline he used to flush his eyes with because he had allergies. During an observation, on 04/13/2026 at 10:18 A.M., the resident was not in his room. The tube of ointment was uncapped and lying on the over-bed table. They syringe of clear fluid was also laying on the table. On 04/13/2026 at 11:46 A.M., the uncapped tube of ointment and the syringe were laying on the resident's over-bed table. The clinical record was reviewed on 04/13/2026 at 11:18 A.M. A Quarterly Minimum Data Set (MDS)assessment, dated 02/03/2026, indicated the resident was cognitively intact. The resident's diagnoses included, but were not limited to, end stage renal disease (kidney function declines to below 10 to 15 percent) and diabetes. The resident received dialysis treatments while a resident. The resident's record lacked a physician's order for the ointment and for the resident to be permitted to self-administer the medication. During an observation and interview, on 04/14/2026 at 10:21 A.M., the MDS Coordinator indicated the ointment was lidocaine (a numbing agent). The ointment and syringe were both on the resident's over-bed table. The MDS Coordinator indicated they should not be left at the bedside, and the resident should have a physician's order for them to be left at bedside. The current undated Medication Administration General Guidelines policy was provided by the Administrator on 04/14/2026 at 4:33 P.M. The policy indicated, .Residents are allowed to self-administer medications when specifically authorized by the attending physician . 410 IAC (Indiana Administrative Code) 16.2-3.1-11(a)

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	155208	A. Building B. Wing	04/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aperion Care Hanover	410 W Lagrange Rd Hanover, IN 47243

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to notify the Ombudsman of residents that were discharged from the facility for 3 of 3 discharged residents' records reviewed. (Residents 81, 79, and 3) Findings include: 1. The clinical record for Resident 81 was reviewed on 04/10/2026 at 2:36 P.M. The resident was admitted to the facility on [DATE] after a lengthy hospital stay. A Nursing Home Discharge Minimum Data Set (MDS) assessment, dated 03/11/2026, indicated the resident discharged to home on [DATE], and was not anticipated to return to the facility. The Census section of the resident's Electronic Health Record (EHR) indicated the resident was discharged from the facility on 02/23/2026. During an interview, on 04/15/2026 at 11:09 A.M., the Social Services Director (SSD) indicated the resident went home with her spouse and declined home health services. She normally sent a list of discharged residents to the Ombudsman every month, but she missed sending the list of residents that discharged in February. 2. The clinical record for Resident 79 was reviewed on 04/10/2026 at 2:34 P.M. A Census Report indicated the resident was discharged on 01/20/2026 and the facility stopped billing on 01/21/2026. A Progress Note, dated 01/20/2026 at 3:40 P.M., indicated the resident was transported to the local emergency room. The clinical record lacked documentation that the Ombudsman was notified of the resident's discharge to the hospital. During an interview, on 04/16/2026 at 9:56 A.M., the SSD indicated she didn't have a way to show that she had notified the local Ombudsman of the resident's discharges. There was no way to show that she submitted it, and she didn't document it in the resident's record. 3. The clinical record for Resident 3 was reviewed on 04/10/2026 at 2:39 P.M. A Nursing Home Discharge MDS assessment, dated 02/05/2026, indicated the resident discharged to home and was not anticipated to return to the facility. During an interview, on 04/14/2026 at 11:36 A.M., the Assistant Director of Nursing (ADON) indicated the SSD notified the Ombudsman monthly related to discharged residents, usually at the first of the month. During an interview, on 04/14/2026 at 11:58 A.M., the SSD indicated she uploaded the discharge reports to the Ombudsman's site per the request of the Ombudsman. The Ombudsman had asked for monthly reports. SSD was taught to email the reports but then the SSD got the request to move the report to a State Ombudsman website. During an interview, on 04/14/2026 at 12:26 P.M., the SSD indicated she had just sent the list of discharged residents for February 2026. She had looked to see if she had sent it earlier and could not find it. She had been sick for a while around that time. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The current Notice of Transfer and Discharge policy, with a reviewed date of 05/08/2023, was provided by the Administrator on 04/15/2026 at 12:32 P.M. The policy indicated, .The facility will send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. This may be done by submitting a monthly list of discharges to the Ombudsman . 410 IAC (Indiana Administrative Code) 16.2-3.1-12(a)(6)(A)IV

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, and interview, the facility failed to identify a Deep Tissue Pressure Injury in a timely manner for 1 of 2 residents reviewed for pressure ulcers. (Resident 67)Findings include:The clinical record for Resident 67 was reviewed on 04/13/2026 at 11:28 A.M. A Quarterly Minimum Data Set(MDS) assessment, dated 02/14/2026, indicated the resident was severely cognitively impaired. The resident's diagnoses included, but were not limited to, respiratory failure (lungs cannot adequately oxygenate the blood or remove carbon dioxide), muscle wasting (decrease in muscle size, mass, and strength). The resident was extensively dependent on staff for assistance with mobility and was non-ambulatory (unable to walk, restricted movement, bedfast) The resident was at risk for developing a pressure ulcer. During an observation and interview, on 04/14/2026 at 9:17 A.M., the facility wound nurse and the Wound Doctor removed a soft protective boot and sock from the resident's left foot. The Wound Doctor indicated the wound was a deep tissue injury (DTI, Persistent non-blanchable deep red, maroon or purple discoloration Intact skin) that now measured 0.8 centimeters (CM) x (by) 0.2 cm. An ultrasonic water treatment had been used on the wound bed. The wound was in the healing process with decreased size and improved appearance. The Skin Monitoring: Comprehensive CNA (Certified Nurse Aide) Shower Review records were provided by the Director of Nursing (DON) on 04/15/2026 at 3:34 P.M., and included the following:- A record, dated 03/03/2026, was blank and did not indicate there were any new skin areas identified,- A record, dated 03/05/2026, was blank and did not indicate there were any new skin areas identified, - A record, dated 03/09/2026, indicated the resident's heels were soft. Nothing was documented regarding the left outer foot. A Preventative Interventions Worksheet, dated 03/03/2026, included a Braden Scale risk assessment (an assessment used for predicting a resident's risk for acquiring pressure wounds) which indicated the resident was at a very high risk for developing a pressure wound. A Wound ASSESSMENT DETAILS REPORT, dated 03/11/2026 at 2:22 P.M., indicated the resident had a facility acquired DTI, identified on 03/10/2026. A Facility Acquired/Worsening Wound Investigation Report, dated 03/17/2026, indicated the resident had an in-house acquired wound identified on 03/11/2026. The new interventions put in place after the identification of the wound, included but were not limited to, off-loading devices. The report lacked any documentation the wound was unavoidable. During an interview on 04/15/2026 at 2:54 P.M., the facility Wound Nurse indicated the facility should have had wound preventative measures in place from the time the resident returned from the hospital on [DATE] to the time the wound was identified on 03/10/2026. The facility failed to provide a policy related to pressure wounds. 410 IAC (Indiana Authorization Code) 16.2-3.1-40(a)(1)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to verify physician orders and accurately transcribe physician orders for 2 of 21 residents reviewed for pharmacy services. (Resident 21 and 14) Findings include:1. During a medication administration observation and interview on 04/15/2026 at 9:31 A.M., Licensed Practical Nurse (LPN) 7 prepared Resident 21's medications. The resident had an order on the Electronic Medication Administration Record (EMAR) for Critical Procure Supplement for wound healing. The order did not have an amount to administer. The LPN indicated the order didn't indicate how much to administer and she would just give the resident 5 cubic centimeters (cc). The nurse poured 5 cc into a medication cup and took the resident's medications into his room. The resident refused the supplement. During an interview, on 9:59 A.M., the Minimum Data Set (MDS) Coordinator indicated if a resident had an order for a liquid supplement, then it should have the amount to be given in the order. Every resident was different based on weight and comorbidities. If an order didn't have an amount to give, then she would call the physician to clarify the order. She reviewed the order for Resident 21 at that time and indicated there should have been an amount to administer. The nurse should have clarified the order. 2a. The clinical record for Resident 14 was reviewed on 04/13/2026 at 10:53 A.M. A Quarterly MDS assessment, dated 02/24/2026, indicated the resident was cognitively intact. The resident's diagnoses included, but were not limited to, heart failure, and hypertension (high blood pressure).A Hospital Discharge Record, dated 04/09/2026, indicated the resident had the following physician's orders:- Midodrine 2.5 milligrams (mg) every eight hours, and - Vancomycin 125 mg, take 1 capsule four times a day for 14 days, three times a day for seven days, two times a day for seven days, daily for seven days, and once a week for seven weeks. The resident's facility physician's orders and April 2026 EMAR indicted the resident had the following orders transcribed after admission to the facility on [DATE]:- Midodrine 2.5 mg with a start date of 04/09/2026 through 04/12/2026, the staff were to give 0.25 mg every eight hours for hypertension, -Vancomycin 125 mg, dated 04/09/2026 through 04/13/2026, take one capsule four times a day for 14 days, -Vancomycin 125 mg, dated 04/10/2026 through 04/13/2026, take one capsule once a day for seven days. During an interview, on 4/15/26 at 8:55 A.M., the Director of Nursing (DON) indicated the resident had duplicate Vancomycin orders and she shouldn't have. During an interview, on 04/13/2026 at 1:36 P.M., RN 2 indicated when a resident received new orders or was admitted from the hospital, the nurse would transcribe the orders and a second nurse wound review and confirm them.During an interview, on 04/14/2026 at 2:53 P.M., the DON indicated the resident's midodrine order was for 2.5 mg. The 0.25 mg part of the order was entered in error. The medication order was corrected. The resident had only received the 2.5 mg.During an interview, on 04/15/2026 at 3:20 P.M., LPN 7 indicated the resident didn't receive duplicate doses of the Vancomycin when she had duplicate orders and the resident had only ever received 2.5 mg of the Midodrine when the order indicated she was to be given 0.25 mg. The medication was reviewed in the medication cart and there were only medication cards from the pharmacy on 03/10/2026 and 04/10/2026 for 2.5 mg tablets. During an interview, on 04/16/2026 at 10:31 A.M., RN 5 indicated if a resident had a duplicate or incorrect order, she would contact the physician to get clarification of the order. 2b. An open-ended physician's order with a start date of 04/10/2026 indicated the resident was to be given Veletri (a prescription medication delivered continuously via a small, portable pump for treating severe pulmonary arterial hypertension) Intravenous Solution Reconstituted. The resident was to receive 3.7 milliliters per hour in the evening for pulmonary hypertension. During an interview, on 04/15/2026 at 1:41 P.M., LPN 7 indicated the resident had a cardio pump for hypertension. The resident medication cartridge would get changed out every 24 hours. The pump would let the staff know when it was empty. The time the medication was changed out varied, it wasn't at the exact same time every day. The only time to (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	document the medication administration on the EMAR was in the evening. She did change the medication out that morning, but there was nowhere for her to document that the medication was administered that morning. During an interview, on 04/15/2026 at 1:48 P.M., the DON indicated the resident received 89 ml/hour of the Veletri medication. There was a 100 mls in the cartridge. The pump was set to deliver 89 mls/24 hours but would use all the medication in that cartridge so it didn't always get changed out at the same time every day. The nurse would document in the EMAR when the medication was changed out. She thought the resident had an as needed order for the nurses to document when it was changed out. It appeared that the as needed order was not entered into the computer when she came back from the hospital, and she only had the evening order. There should have been an as needed order in the clinical record. The current facility policy titled, Physician Orders-Entering and Processing, with a revision date of 01/31/2018, was provided by the Administrator on 04/15/2026 at 11:06 A.M. The policy indicated, .To provide general guidelines when receiving, entering, and confirming physician or prescriber's orders.Medication orders should include:.Dose.Notify the resident's physician.for verification if applicable.The current facility policy titled, Transcription of Physician Orders-Procedure, dated 11/03/2022, was provided by the Administrator on 04/15/2026 at 11:06 A.M. The policy indicated, .To establish the procedure by transcribing new physician orders.Transcription of physician orders: Carefully, review transfer record and discharge summary from the hospital or the transfer record.After each order is entered in the physician Order tab of the chart, check that all orders were entered correctly.The current, undated, facility policy titled, Medication Administration General Guidelines was provided by the Administrator on 04/14/2026 at 4:33 P.M. The policy indicated, .Medications are administered as prescribed in accordance with good nursing principles and practices.FIVE RIGHTS-.right dose.410 IAC (Indiana Administrative Code) 16.2-3.1-25(b)(9)410 IAC (Indiana Administrative Code) 16.2-3.1-37(a)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on record review and interview, the facility failed to follow pharmacy recommendations related to completing an Abnormal Involuntary Movement Scale (AIMS) assessment for a resident receiving an antipsychotic medication for 1 of 5 residents reviewed for unnecessary medications. (Resident 4) Findings include:The clinical record for Resident 4 was reviewed on 04/15/2026 at 10:04 A.M. A Quarterly Minimum Data Set (MDS) assessment, dated 03/04/2026, indicated the resident was moderately cognitively impaired. The resident's diagnosis included, but was not limited to, psychotic disorder. The resident received an antipsychotic medication at the time of the assessment. The resident's most recent AIMS assessment was completed on 07/30/2025. A Consultant Pharmacist Recommendations to Nursing record, dated 01/26/2026, indicated the resident received Risperidone, an antipsychotic medication requiring adverse effect monitoring via an AIMS assessment. The most recent AIMS was completed on 07/30/2025. It was recommended an AIMS be performed within 30 days of initiation of the medication and repeated every six months or with any dose increase while the resident continued antipsychotic therapy. The medication had been increased on 12/31/2025. During an interview, on 04/15/2026 at 10:04 A.M., the Director of Nursing (DON) indicated the resident should have had an AIMS assessment completed following the recommendation from the pharmacy and it was not completed. 410 IAC (Indiana Administrative Code) 16.2-3.1-25(i)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on record review and interview, the facility failed to document a resident's medication administration for 1 of 21 residents record reviewed. (Resident 14)Findings include:The clinical record for Resident 14 was reviewed on 04/13/2026 at 10:53 A.M. A Quarterly Minimum Data Set (MDS) assessment, dated 02/24/2026, indicated the resident was cognitively intact. The resident's diagnoses included, but were not limited to, heart failure (the heart muscle cannot pump enough blood to meet the body's needs for oxygen and nutrients) and hypertension (chronic high blood pressure).An open-ended physician's order, with a start date of 04/10/2026, indicated the resident was to be given Veletri (a prescription medication delivered continuously via a small, portable pump for treating severe pulmonary arterial hypertension) Intravenous Solution Reconstituted. The resident was to receive 3.7 milliliters per hour in the evening for pulmonary hypertension. The April 2026 Electronic Medication Administration Record lacked documentation that the medication was administered on 04/10/2026, 04/11/2026, and 04/12/2026. During an interview, on 04/15/2026 at 1:41 P.M., Licensed Practical Nurse (LPN) 7 indicated the resident had a cardiac pump for pulmonary hypertension. The resident's medication would get changed out every day.During an interview, on 04/13/2026 at 1:36 P.M., RN 2 indicated medications were always signed out in the residents EMAR. There should never be blanks in the EMAR. The current, undated, facility policy titled, Medication Administration General Guidelines was provided by the Administrator on 04/14/2026 at 4:33 P.M. The policy indicated, .The individual who administers the medication dose records the administration on the resident's MAR [Medication Administration Record] directly after the medication is given.In no case should the individual who administered the medications report-off duty without first recording the administration of any medication.410 IAC (Indiana Administrative Code) 16.2-3.1-50(a)(1)