STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155254	A. Building B. Wing	09/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aperion Care Greenfield	5430 W US 40 Greenfield, IN 46140

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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 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 observation, interview, and record review, the facility failed to implement interventions as care planned for Resident 7's edema, failed to follow the user manual's guidelines for safe operation of a Broda chair for Resident 5, failed to set up a gynecologist appointment for Resident 18, failed to complete neurological checks for Resident 40 after an unwitnessed fall, and failed to monitor, document, and address drooling for Resident 8. The deficient practice affected 5 of 5 residents reviewed for quality of care. Findings include: 1. The clinical record for Resident 7 was reviewed on 9/29/2025 at 2:35 p.m. The medical diagnoses included atypical atrial flutter and schizophrenia. A Quarterly Minimum Data Set (MDS) assessment, dated 8/27/2025, indicated Resident 7 was cognitively intact and did not use diuretics. A cardiovascular care plan, initiated 6/9/2024 and last revised 6/9/2025, indicated to monitor for, document, and notify the provider of any edema. An order for a bilateral lower extremity doppler was ordered, on 9/23/2025, with a diagnosis of venous insufficiency. During an interview and observation on 9/25/2025 at 1:52 p.m., Resident 7 stated his legs were swollen and red. Resident 7's socks were noted to be indenting his ankles and redness was noted to his shins. A weekly skin assessment, dated 9/26/2025, indicated Resident 7 did not have edema. An interview and observation were conducted on 9/26/2025 at 12:03 p.m. Resident 7's socks were indenting into his ankles. Resident 7 indicated his ankles felt swollen and the Nurse Practitioner (NP) was working on getting him medicine to help with the swelling. During an interview on 9/26/2025 at 12:05 p.m., Qualified Medication Aide (QMA) 5 indicated Resident 7's legs were .usually like that, referring to his socks indenting his ankles and the red color. When asked how long they had been swollen, she stated she was not sure. During an observation on 9/29/2025 at 12:14 p.m., Resident 7 was noted to be sitting in the hallway. Resident 7's socks were noted to be indenting into his ankles and his shins were reddened. During an interview on 9/29/2025 at 1:05 p.m., the Assistant Director of Nursing (ADON) indicated Resident 7 was having some swelling and redness to his legs. The ADON reported to the NP and followed up with the NP when the doppler results were in, on 9/24/2025, and received no new orders. (continued on next page)

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the NP on 9/30/2025 at 10:05 a.m., the NP indicated Resident 7 approached her last week with some bilateral lower leg swelling and redness. She ordered a doppler and would be following up on Resident 7 today. Staff did not report any change between the 9/23/2025 visit and today. 2. The clinical record for Resident 5 was reviewed on 9/26/2025 at 11:45 a.m. The medical diagnosis included bipolar disorder and chronic obstructive pulmonary disease. An Annual MDS assessment, dated 9/5/2025, indicated Resident 5 was not cognitively intact, did not refuse care, had a 6 month or less prognosis, and was on hospice. Resident 7 was dependent on staff for transferring and utilizing a wheelchair. A care plan, dated 2/14/2025 and revised on 6/12/2025, indicated Resident 5 needed assistance with activities of daily living, including the use of a Broda chair. During an interview and observation on 9/25/2025 at 11:38 a.m., Resident 5 was in a Broda chair in the dining area with the footrest broken off. QMA 5 indicated the footrest had been broke off for awhile, but she wasn't sure how long. During an observation on 9/25/2025 at 12:50 p.m., Resident 5 was in a Broda chair in the dining area with the footrest broken off.During an interview on 9/25/2025 at 12:55 p.m., the Administrator indicated Resident 5's Broda chair broke yesterday and they were waiting for a replacement. A Broda chair user manual entitled, Broda Operating Manual, was provided by the ADON on 9/29/2025 at 2:10 p.m. The user manual indicated, .If a breakage, defect, or operational problem is detected, the chair must be successfully repaired, inspected and tested for function before it is returned to service. 3. The clinical record for Resident 18 was reviewed on 9/30/25 at 1:10 p.m. Her diagnoses included, but were not limited to, hemiplegia and hemiparesis. The 8/5/25 NP (Nurse Practitioner) 9 note indicated, The patient reports menorrhagia lasting approximately 7 days per cycle. Due to hemiplegia and hemiparesis on her left non-dominant side, she experiences difficulty accessing and using the bathroom in her facility, which is not fully handicap accessible. She expresses interest in either oral contraceptives or a referral to an OBGYN [obstetrician/gynecologist] for hormonal IUM [intra uterine device] placement to help regulate and lighten her menses. She is due for a breast cancer screening mammogram and colorectal cancer screening, but prefers to delay the latter until after her OBGYN consultation and mammogram .Assessment and Plan .Heavy menstrual bleeding: Patient experiences heavy menses lasting around 7 days, complicating her ability to manage hygiene due to hemiplegia and hemiparesis on her left non-dominant side. Plan: Prescribed Norgestrel 0.075 mg [milligrams] tablet, one tablet daily, to manage heavy menses while awaiting OBGYN appointment. Referred patient to OBGYN for evaluation and potential hormonal IUD placement to regulate and lighten menses. The 8/5/25 physician's order indicated to refer for mammogram for breast cancer screening and to an OB/GYN pap smear and IUD placement for management of heavy menses. There was no information in the clinical record that indicated an OB/GYN appointment was scheduled for Resident 18. An interview was conducted with NP 9 on 9/30/25 at 12:54 p.m. She indicated when she made referrals for outside services, it took the facility a long time to make appointments, and residents didn't always get to their scheduled appointments due to transportation issues and those missed (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	appointments weren't always rescheduled. Resident 18 was due for a colonoscopy and mammogram, and was having horrible menses, soaking through her clothes. NP 9 made multiple referrals for her to be seen by an OB/GYN over the past month, but she was unsure of the status. She wasn't sure where appointments were documented once scheduled, because they were not in the orders section of the electronic health record. An interview was conducted with the ADON on 9/30/25 at 1:21 p.m. He indicated neither a mammogram nor an OB/GYN appointment was scheduled for Resident 18. He'd sent paperwork for the mammogram appointment and was waiting to hear back about an appointment. The OB/GYN appointment still needed to be scheduled. He did not know why there was a delay in scheduling the OB/GYN appointment, since the order to do so was from 8/5/25. 4. The clinical record for Resident 8 was reviewed on 9/25/25 at 12:45 p.m. His diagnoses included, but were not limited to, paranoid schizophrenia and personality disorder. The physician's orders indicated he was prescribed Invega Sustenna (antipsychotic medication) intramuscularly one time a day every 30 days and olanzapine (antipsychotic medication) 10 mg tablet by mouth two times a day, both for schizophrenia. The 8/27/24 psychotropic medication care plan indicated he used antipsychotic medications related to paranoid schizophrenia and personality disorder. The goal was for him to be/remain free of psychotropic drug related complications, including movement disorder, discomfort, hypotension, gait disturbance, constipation/impaction or cognitive/behavioral impairment through the next review date. An intervention was to administer psychotropic medications as ordered by the physician, and to monitor for side effects and effectiveness every shift. Another intervention was to monitor/document/report as needed, any adverse reactions of psychotropic medications: unsteady gait, tardive dyskinesia, EPS (extrapyramidal symptoms) (shuffling gait, rigid muscles, shaking), frequent falls, etc. and behavior symptoms not usual to the person. An interview was conducted with the ADON on 9/29/25 at 3:21 p.m. He indicated they documented monitoring of side effects of psychotropic medications on the MAR (medication administration record). There was no documentation in the clinical record, including the MAR, to indicate Resident 8 was currently monitored for side effects of antipsychotic medications every shift, as care planned, nor was there an order to do so. An observation of Resident 8 was conducted on 9/25/25 at 12:47 p.m. He was sitting in his wheelchair in the dining room at a table. He was drooling and both hands were shaking consistently. An observation of Resident 8 was conducted on 9/30/25 at 10:00 a.m. He was sitting in his wheelchair in the hallway. His head was down, and he wiped drool from his mouth with a white blanket that was around his neck. Both hands were shaking continuously. An observation of Resident 8 was conducted with the ADON on 9/30/25 at 10:10 a.m. An interview was conducted with the ADON at that time. Resident 8 was sitting in his wheelchair in the hallway. His head was down, and he had drool dripping from his mouth down to his lap. His hands were shaking more aggressively than during the observation on 9/30/25 at 10:00 a.m. The ADON indicated he saw the drooling and hand shaking and would notify their psychiatric provider. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted with the ADON on 9/30/25 at 10:08 a.m. He indicated the hand shaking and drooling were new symptoms for Resident 8. He reviewed his clinical record and indicated he didn't see any diagnosis or condition to which the symptoms could be attributed. An interview was conducted with CNA (Certified Nurse Aide) 7 on 9/30/25 at 10:38 a.m. She indicated Resident 8 had been drooling since she began working there on 4/11/24. She gave him paper towels to wipe the drool, when she noticed it, or she would wipe his mouth for him. The hand shaking began around six months ago. She'd spoken with QMA (Qualified Medication Aide) 3 about it. An interview was conducted with QMA 3 on 9/30/25 at 10:40 a.m. She indicated NP (Nurse Practitioner) 9 saw him last week about the drooling. An interview was conducted with NP 9 on 9/30/25 at 12:54 p.m. She indicated she did not know the drooling was a routine thing for him and had been happening for so long. It was concerning if it was happening a lot. No one told her it was a regular thing. The 9/12/25 psychotropic medication observation assessment did not have drooling or tremor check marked under the EPS symptoms section. An interview was conducted with the ADON on 9/30/25 at 11:04 a.m. He indicated he left a message with their psychiatric provider to inform of Resident 8's drooling and hand tremors, but he hadn't heard back yet. The Psychotropic Medication-Gradual Dosage Reduction policy was provided by the ADON on 9/30/35 at 11:25 a.m. It indicated, Staff will monitor residents for side effects, withdrawal symptoms and/or changes in behavior and report to physician and/or psychiatrist. Documentation of observed side effects by nursing staff will occur as indicated in the Nurses Notes and/or on the EMAR [electronic medication administration record.] 5. The clinical record for Resident 40 was reviewed on 9/29/25 at 2:26 p.m. The diagnoses included, but were not limited to, cognitive communication disorder, unspecified lack of coordination, and major depressive disorder. A nurse's note, dated 9/24/25 at 10:50 a.m., indicated Resident 40 had an unwitnessed fall out of his wheelchair and neurological checks were initiated. A fall risk assessment, dated 9/24/25 at 11:55 a.m., indicated Resident 40 was at risk for falls. The Quarterly MDS assessment, dated 6/20/25, indicated Resident 40 was moderately to severely cognitively impaired, used a wheelchair for ambulation, and required supervision or touching assistance with chair/bed-to-chair transfers. During a review of the Neuro Check forms provided by the Social Service Director (SSD) on 9/29/25 at 1:10 p.m., it indicated neuro checks were not completed from 9/24/25 at 10:02 p.m. to 9/25/25 at 6:39 p.m. Omissions were for 9/25/25 at 2:00 a.m., 6:00 a.m., and 10:00 a.m. The plan of care for Resident 40, dated 6/11/19, indicated the resident had a potential for falls related to gait/balance and dementia. The interventions included, but were not limited to, follow facility fall protocol. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the Director of Nursing (DON) on 9/29/25 at 2:26 p.m., indicated she did not know why neuro checks for Resident 40 were not completed every 4 hours for 24 hours. The DON indicated the nursing department was responsible to ensure these checks were completed. A Neurological Assessment policy was provided by the SSD on 9/29/25 at 1:10 p.m. It indicated, .4. Unless otherwise ordered by the physician, neuro checks will be completed at the time of the physician order, potential head injury or change in condition and every 4 hours for 24 hours . 3.1-37(a) 3.1-37(b)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview and record review, the facility failed to ensure the narcotic reconciliation records were signed by the on-going nursing staff and the off-going nursing staff at each of three (3) shift changes daily to reflect the accuracy of the narcotic medication counts and the facility did not maintain expired medications within the facility for 1 of 1 resident. These actions had the potential to adversely affect all residents of the facility that receive narcotic medications and 1 of 1 resident who had one expired medication. (Resident 24) Findings include:1. An observation of the narcotic count sheets was conducted with Qualified Medication Aide (QMA) 3, on 9-26-25 at 11:55 a.m., for the facility's east medication cart for September, 2025. The form was set up to reflect the unit or hall for the count sheet, with entries to reflect each date for the month, entries to reflect the three shifts, identified as first, second and third shift, as well as entries to reflect the signature or initials of the nursing staff that was leaving the shift, specified as off, and the nursing staff that was coming on duty for the shift, specified as on. Several dates were observed to be blank, reflective of a lack of a narcotic count being conducted by the nursing staff for the east hall. Those specific dates were as follows: - 9-3-25, first shift.- 9-11-25, first shift.- 9-17-25, second and third shifts.- 9-18-25, first shift. An observation of the narcotic count sheets was conducted with QMA 4, on 9-29-25 at 10:04 a.m., for the facility's west medication cart for August and September, 2025. The form was set up to reflect the unit or hall for the count sheet, with entries to reflect each date for the month, entries to reflect the three shifts, identified as first, second and third shift, as well as entries to reflect the signature or initials of the nursing staff that was leaving the shift, specified as off, and the nursing staff that was coming on duty for the shift, specified as on. Several dates were observed to be blank, reflective of a lack of a narcotic count being conducted by the nursing staff for the west hall. Those specific dates were as follows: - 8-4-25, first shift.- 8-18-25, first shift.- 8-31-25, first shift. During an interview with the Administrator on 9-30-25 at 1:15 p.m., she indicated she was unaware of any dates in which the narcotic count logs were unsigned on either hall. That is something I should have been made aware of. 2. An observation of the west hall medication storage room, including the locked refrigerator, was conducted on 9-29-25 at 10:04 a.m., with QMA 4. During the observation, a box of six (6) Bisacodyl Suppositories, a stimulant laxative, for Resident 24, was observed. This box had an expiration date of 2-28-25. The labeled instructions indicated this medication was to be administered once every eight hours as needed for constipation. QMA 4 indicated she was unaware of this resident using this medication on a regular basis. On 9-30-25 at 10:15 a.m., the Director of Nursing provided a copy of a policy entitled, Narcotic/Controlled Substances-Counting, and dated 11-26-17. This policy indicated its purpose was, To count controlled substances with a partner and to verify the accuracy of the log sheets, and Knowledge of correct response should an error be discovered in the controlled substance count. It indicated, Always participate in the counting of the controlled substances at the beginning and ending of your shift. Never say, 'go ahead without me and I'll sign later.' Never leave it to someone else's discretion when you are the one on duty. If you do not observe the medications that you sign as being present, you may be implicated if the medications are later missing .Follow your facilities [sic] specific guidelines and use their specific log sheet. Obtain sign-out records/logs and keys to the controlled storage compartment. Have partner to assist in the count .Sign name, time and date of completed count .Procedure for Responding to Errors in a Controlled Substance Count: Obtain sign-out logs and keys to the controlled storage compartment. Have partner to assist in the count .Report the incorrect count to the nursing supervisor, Director of Nursing, or administrative staff present. On 9-29-25 at 3:21 p.m., the Assistant Director of Nursing provided a copy of a policy, dated 7-2-19, and entitled Medication Storage. This policy's purpose was cited as, To ensure proper storage, labeling and expiration dates of medications, biologicals, syringes, and needles. This policy indicated, Facility should ensure that (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	medications and biologicals that: (1) have an expired date on the label .are stored separate from other medications until destroyed or returned to the supplier . 3.1-25(e)(3)3.1-25(o)

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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, interview, and record review, the facility failed to assist a resident with putting on a bra, provide a resident with clean clothes and geriatric chair, and transport a resident in a geriatric chair in a dignified manner by pulling them backwards for 3 of 3 residents reviewed for dignity (Resident 38, Resident 5 and Resident 24). Findings include: 1. During an observation conducted on 9/25/25 at 12:20 p.m., Resident 38 was sitting in front of the dining room fully dressed. The resident had no bra in place. During an observation conducted on 9/26/25 at 12:10 p.m., Resident 38 was sitting in front of the dining room fully dressed with no bra in place. During an observation conducted on 9/29/25 at 1:18 p.m., Resident 38 was sitting in front of the dining room fully dressed with no bra in place. During an observation conducted on 9/30/25 at 11:25 a.m., Resident 38 was in the dining room in an activity with several other residents. She was fully dressed with no bra in place. During an interview with the Director of Nursing (DON) on 9/29/25 at 1:22 p.m., they indicated the nursing staff would be responsible to ensure Resident 38 had a bra on. Review of the record of Resident 38, on 9/29/25 at 1:50 p.m., indicated the resident's diagnoses included, but were not limited to, multiple rib fractures, fractures of nasal bones, vascular dementia, and unsteady gait. The Quarterly Minimum Data Set (MDS) assessment for Resident 38, dated 9/2/25, indicated the resident was severely impaired for daily decision making. The resident had no behaviors of refusal of care. The resident required partial/moderate assistance with dressing and putting on footwear. 2. The clinical record for Resident 5 was reviewed on 9/26/25 at 11:45 a.m. The medical diagnosis included bipolar and chronic obstructive pulmonary disease. An Annual MDS assessment, dated 9/5/25, indicated Resident 5 was not cognitively intact, did not refuse care, had a 6 month or less prognosis, and was on hospice. Resident 5 was dependent on staff for transferring and utilizing a wheelchair. A care plan, dated 10/21/24 and revised on 2/15/25, indicated Resident 5 would have a clean appearance. Interventions included Resident 5 was dependent on staff for hygiene needs. During an observation on 9/25/25 at 11:38 a.m., Resident 5 was in a Broda chair in the dining area. Resident 5 was noted to have food debris on his face, shirt, and Broda chair. Resident 5 did not have any food or drink evident, and no staff were directly assisting him. During an observation on 9/25/25 at 12:50 p.m., Resident 5 had finished lunch at this time. He was sitting in his Broda chair in the dining room with food debris on his shirt, face, and Broda chair. During an interview on 9/29/25 at 1:05 p.m., the Assistant Director of Nursing (ADON) indicated it was the expectation of the direct care staff to assist Resident 5 with cleanliness. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. The clinical record for Resident 24 was reviewed on 9/25/25 at 12:20 p.m. His diagnoses included, but were not limited to, dementia, hemiplegia, chronic obstructive pulmonary disease, left thigh contracture, and right shoulder contracture. An observation of Resident 24 being assisted out of the dining room in his Broda chair was conducted on 9/29/25 at 12:55 p.m. QMA (Qualified Medication Aide) 5 pulled him backwards through the dining room. While pulling him, the side of his Broda chair hit the side of the vending machine. A long, metal strip attached to the side of the vending machine came unattached and fell onto the floor by Resident 24. QMA 5 had a shocked look on her face and stopped pulling him. An interview was conducted with QMA 5 on 9/29/25 at 12:57 p.m. She indicated it was easier to pull Resident 24 backwards in his chair, because the wheels moved back and forth, when she tried to push him forward. The metal strip that came off of the side of the vending machine had fallen off before. It could be popped back into place. An interview was conducted with the DON on 9/29/25 at 1:56 p.m. She indicated staff should push residents in their Broda chairs, not pull them. It was a dignity and safety concern. The Dignity policy was provided by the ADON on 9/29/25 at 3:21 p.m. It indicated, The facility shall promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. The facility shall consider the resident's life style and personal choices identified through the assessment processes to obtain a picture of his or her individual needs and preferences. Staff shall carry out activities in a manner which assists the resident to maintain and enhance his/her self-esteem and self-worth. 3.1-3(t)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. Based on interview and record review, the facility failed to accurately encode a Minimum Data Set (MDS) assessment for 1 of 2 residents reviewed for hospice. (Resident 5)Findings include:The clinical record for Resident 5 was reviewed on 9/26/2025 at 11:45 a.m. The medical diagnosis included bipolar and chronic obstructive pulmonary disease.An Annual MDS assessment, dated 9/5/2025, indicated Resident 5 was not cognitively intact, did not refuse care, had a 6 month or less prognosis, and was on hospice.A nursing progress note, dated 8/28/2025, indicated Resident 5 was discharged from hospice.A census change, dated 8/28/2025, indicated Resident 5's payor source was changed from hospice to Medicaid. During an interview on 9/29/2025 at 1:45 p.m., the Assistant Director of Nursing (ADON) indicated Resident 5 was discharged from hospice and they were currently trying to get Resident 5 admitted to a new hospice company, but Resident 5 was currently not on hospice care. During an interview on 9/29/2025 at 2:05 p.m., the MDS Coordinator indicated it was the expectation to code to the Resident Assessment Instrument User Manual. Resident 5's hospice status was coded based on the active orders, but a modification would be initiated to reflect Resident 5's status at the time of assessment.A policy entitled Resident MDS Assessment and Care Planning Standard was provided by the ADON on 9/29/2025 at 2:10 p.m. The policy indicated all assessments are to be completed timely and accurately for the Resident Assessment Instrument Manual.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, interview, and record review, the facility failed to implement an intervention after a fall, failed to provide appropriate footwear, and failed to have fall interventions in place as care planned for 2 of 2 residents reviewed for falls (Resident 38 and Resident 24). Findings include: 1. During an observation on 9/25/2025 at 12:20 p.m., Resident 38 had on house slippers with no nonskid soles on her feet while sitting in a regular chair. The resident was assisted into a wheelchair with standby assistance provided. During an observation on 9/26/2025 at 12:10 p.m., Resident 38 was sitting in a wheelchair with slippers on with no nonskid soles. During an observation on 9/29/2025 at 12:46 p.m., Resident 38 was sitting at the dining room table, with slippers on with no nonslip grip. During an observation on 9/30/25 at 11:25 a.m., Resident 38 was in the dining room with house slippers with no nonskid soles. During an interview with Certified Occupational Therapist Assistant (COTA) on 9/29/2025 at 12:36 p.m., they indicated she was not able to find where therapy had evaluated or treated Resident 38 since January 2025. During an interview with the Therapy Manager on 9/29/2025 at 12:39 p.m., they indicated Resident 38 was last treated by therapy from 1/23/25 to 2/20/25. Review of the record of Resident 38, on 9/29/25 at 1:50 p.m., indicated the resident's diagnoses included, but were not limited to, multiple rib fractures, fractures of nasal bones, vascular dementia, and unsteady gait. The Quarterly Minimum Data Set (MDS) assessment for Resident 38, dated 9/2/25, indicated the resident was severely impaired for daily decision making. The resident required partial/moderate assistance with putting on footwear. The resident was independent with transfers and ambulation. The plan of care for Resident 38, dated 3/5/25, indicated the resident had a fall related to unsteady gait. The interventions included, but were not limited to, encourage resident to wear gripper socks, wear proper footwear and Physical Therapy to evaluate and treat when the resident returns to the facility from the hospital (7/23/25). This indicated no other interventions were implemented after Resident 38 fell. The fall risk assessment for Resident 38, dated 4/21/25, indicated the resident was at risk for falls. The fall risk assessment for Resident 38, dated 7/21/25, indicated the resident was at risk for falls. A progress note for Resident 38, dated 7/21/25 at 10:49 a.m., indicated the resident had a witnessed fall outside the shower room. The resident was walking and tripped on her shoe. The resident had an open area on the left side of her nose (pressure applied due to bleeding). The Physician was notified and an x-ray was ordered. (continued on next page)

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	155254	A. Building B. Wing	09/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aperion Care Greenfield	5430 W US 40 Greenfield, IN 46140

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A progress note for Resident 38, dated 7/21/25 at 9:40 p.m., indicated the x-ray results came back and the resident had fractured ribs. A progress note for Resident 38, dated 7/22/25 at 1:31 p.m., indicated the resident was transported to the local hospital. A progress note for Resident 38, dated 7/22/25 at 4:53 p.m., indicated the resident was being transported from the local hospital to a major medical hospital for admission. The hospital discharge summary for Resident 38, dated 7/25/25, indicated the resident was admitted for a fall with traumatic injuries. The resident was at high risk for falls due to medical and physical impairment. The resident acquired a fracture of on the right side of ribs 3-7 and fracture on the left side of the ribs 3-8, sinus contusion with hematoma and nasal bone fracture. The Occupational Therapy and Physical Therapy recommendations were the resident would benefit from ongoing therapy when returned to the Extended Care Facility (ECF). During an interview with Director of Nursing (DON) on 9/29/25 at 1:22 p.m., they indicated the Interdisciplinary Team (IDT) were responsible to ensure Resident 38 had a fall intervention implemented after the resident fell. The DON indicated nursing staff were responsible to ensure Resident 38 had on appropriate footwear to prevent falls. 2. The clinical record for Resident 24 was reviewed on 9/25/25 at 12:20 p.m. His diagnoses included, but were not limited to, dementia, hemiplegia, chronic obstructive pulmonary disease, left thigh contracture, and right shoulder contracture. The fall care plan, revised 5/1/25, indicated he had actual falls related to gait/balance problems, decreased safety awareness, shortness of breath with activity, dementia, and psychotropic medication use. Interventions were to ensure the television remote was within reach; a safe environment with a working and reachable call light; call light within reach and encourage the resident to use it for assistance as needed; and bed in lowest position at all times. An observation of Resident 24 was conducted on 9/29/25 at 1:12 p.m. He was lying awake in bed in his room. His bed was not in the lowest position; there was no television remote within reach, and the television was on; and his call light cord was wedged between the wall and the mattress with the actual call light not within reach. There were no staff present in the room. An observation of Resident 24 was conducted with CNA (Certified Nurse Aide) 8 on 9/29/25 at 1:20 p.m. An interview was conducted with CNA 8 at that time. The call light cord was still wedged between the wall and the mattress. CNA 8 pulled on the cord for a while to retrieve the actual light and placed it on top of Resident 24. CNA 8 indicated Resident 24 was not able to pull the cord from between the wall and mattress himself, as he required total assistance. CNA 8 then retrieved the television remote from a drawer in his room. CNA 6 entered the room and used the bed remote to lower the bed to its' lowest position. The Fall Prevention Program policy was provided by the SSD (Social Services Director) on 9/29/25 at 1:10 p.m. It indicated, Purpose: To assure the safety of all residents in the facility, when possible. The program will include measures which determine the individual needs of each resident by assessing the risk of falls and implementation of appropriate interventions to provide necessary supervision and assistive devices are utilized as necessary Guidelines: .Care plan incorporates: .Interventions are (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	changed with each fall, as appropriate .Standards: .Safety interventions will be implemented for each resident identified at risk .Fall/Safety interventions may include but are not limited to: .The nurse call device will be placed within the resident's reach at all times .The resident's personal possessions will be maintained within reach when possible .Foot wear will be monitored to ensure the resident has proper fitting shoes and/or footwear is non-skid. 3.1-45(a)(1) 3.1-45(a)(2)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on interview and record review, the facility failed to follow a physician's order to flush an indwelling catheter (a thin, flexible tube inserted into the bladder to drain urine continuously) with normal saline every shift as ordered for 1 of 1 resident reviewed for catheter care. (Resident 40)Findings include: The clinical record for Resident 40 was reviewed on 9/29/2025 at 11:07 a.m. The diagnoses included, but were not limited to, neuromuscular dysfunction of the bladder, dementia, and benign prostatic hyperplasia (the prostate gland, located below the bladder in men, enlarges) with lower urinary tract symptoms. The Quarterly Minimum Data Set assessment, dated 6/20/25, indicated Resident 40 had an indwelling catheter. A physician's order, dated 2/24/24, indicated to irrigate/flush catheter with 30 cc (milliliters) of normal saline every shift. The September 2025 Medication Administration Record (MAR) was reviewed on 9/29/25 at 11:30 a.m. It indicated a physician's order for catheter: irrigate/flush with 30 cc (milliliters) of normal saline every shift. Omissions indicated for day shift for the following dates: 9/5/25, 9/12/25, 9/16/25, 9/17/25, 9/23/25, and 9/24/25. During an interview with the Director of Nursing (DON) on 9/29/25 at 2:36 p.m., they indicated they did not know why these medication omissions occurred and the nurse who was caring for the resident was responsible to ensure orders were followed. 3.1-41(a)(2)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 only medications with appropriate labels were present in 1 of 2 medication carts during 1 of 2 medication cart observations. (Facility) Findings include:On 9-29-25 at 10:04 a.m., an observation of the west hall medication cart was conducted with Qualified Medication Aide (QMA) 4. One bottle of Milk of Magnesia, a saline laxative, was observed which had only the manufacturer's label present. There was no labeling present which indicated the resident's full name, physician's name, specific physician instructions for use, prescription number, date of issue, date opened, or name and address of the pharmacy which dispensed the medication. The label appeared to have been torn off. In an interview with QMA 4 at this time, she indicated it appeared as if the label had been torn off the bottle in some manner as a small piece of label-type material was located on the side, but was without any identifying information. The manufacturer's label indicated directions for use which included, but was not limited to, administer 2 to 4 tablespoons daily, preferably at bedtime which can be given in divided doses and/or as directed by the physician, and to give with 8 ounces of fluid with each dose. On 9-29-25 at 3:21 p.m., the Assistant Director of Nursing provided a copy of a policy, dated 7-2-19, and entitled Medication Storage. This policy's purpose was cited as, To ensure proper storage, labeling and expiration dates of medications, biologicals, syringes, and needles. This policy indicated, Facility should destroy and reorder medications and biologicals with soiled, illegible, worn, makeshift, incomplete, damaged, or missing labels. 3.1-25(j)3.1-25(k)(1)3.1-25(k)(2)3.1-25(k)(3)3.1-25(k)(4)3.1-25(k)(5)3.1-25(k)(6)3.1-25(k)(7)3.1-25(l)(1)3.1-25(l