| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 155572 | A. Building<br>B. Wing | 02/06/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Aperion Care Demotte | 10352 N 600 E County Line Rd<br>Demotte, IN 46310 |

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| F 0602<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Protect each resident from the wrongful use of the resident's belongings or money.<br><br>20580<br><br>Based interview and record review, the facility failed to ensure residents were free from misappropriation of resident property related to drug diversions of residents' narcotic pain medications (hydrocodone and oxycodone) for 3 of 3 residents reviewed for misappropriation of resident property. (Residents B, F, and G) The deficient practice was corrected on 1/3/25, prior to the start of the survey, and was therefore past noncompliance.<br><br>Finding includes:<br><br>A Indiana Department of Health (IDOH) reported incident indicated on 12/27/24 at 10:01 a.m., it was reported to the Assistant Director of Nursing and the Administrator that the facility was unable to account for a Resident B's narcotic pain medication or oxycodone 15 mg (milligrams).<br><br>A 5-Day Follow-up to the reported incident, dated 1/3/25, indicated a registered nurse had admitted to taking Resident B's oxycodone 15 mg.<br><br>The investigation of the incident, undated and completed by the RN Nurse Consultant, indicated all residents' medications and count sheets were reviewed. There were discrepancies for the narcotic pain medications for Residents B, F, and G.<br><br>Review of the resident records and investigation indicated the following:<br><br>1. Resident B's record was reviewed on 2/6/25 at 11:02 a.m. The diagnoses included, but were not limited to, peripheral neuropathy and diabetes mellitus.<br><br>A Physician's Order, dated 10/12/24, indicated oxycodone 15 mg was to be administered every four hours as needed for pain rated at 5-10.<br><br>The pharmacy delivery sheets indicated 30 tablets of oxycodone 15 mg were delivered on on November 5, 16, 21, 24, and 27, 2024, and December 3, 9, 18, 21, and 26, 2024, for a total of 300 tablets.<br><br>The narcotic count records were unable to be located for the deliveries on November 5, 24, and 27, 2024 and December 3, 18, and 21, 2024.<br><br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0602<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The Medication Administration Records (MARs), dated 11/2024 and 12/2024, indicated 12 tablets of oxycodone 15 mg were given in November and 15 tablets given in December. A total of 273 oxycodone 15 mg were unaccounted for.<br><br>2. Resident F's record was reviewed on 2/6/25 at 2/6/25 at 2 p.m. The diagnoses included, but were not limited to, diabetes mellitus and dementia.<br><br>The Quarterly Minimum Data Assessment, dated 12/2/24, indicated a severely impaired cognitive status.<br><br>A Physician's Order, dated 5/18/24 and discontinued on 12/23/24, indicated hydrocodone-acetaminophen 5-325 mg was to be administered as needed every six hours for breakthrough pain.<br><br>The investigation indicated the hydrocodone was signed out by RN 4 on the narcotic count sheets on October 25, 27 (twice), 29, and 30 (twice), 2024, November 1, 4, 5 (twice), 9, 10, 11, 12, 21, 23 (twice), and 28, 2024, and December 2, 3, 5, and 12, 2024.<br><br>The MAR, dated 11/2024 and 12/2024, indicated the medication was only signed out as administered on 10/27/24 and 11/2024.<br><br>There were 22 tablets of hydrocodone 5-325 mg unaccounted for and not documented as received by the resident.<br><br>3. Resident G's record was reviewed on 2/6/25 at 2:15 p.m. The diagnoses included, but were not limited to, osteoarthritis.<br><br>A Physician's Order, dated 9/9/24, indicated hydrocodone-acetaminophen 10-325 mg was to be given every 6 hours as needed for moderate pain.<br><br>The pharmacy delivery sheets indicated 30 tablets of hydrocodone 10-325 mg was delivered on 11/1/24, 11/10/24, 11/20/24, 11/27/24 and 12/3/24 for a total of 150 tablets.<br><br>The narcotic count records were unable to be located for the deliveries on 11/1/24, 11/20/24, 11/27/24, and 12/3/24.<br><br>The MARs, dated 11/2024 and 12/2024, indicated there were 60 tables given in November and 65 tablets given in December. A total 125 tablets were signed as given. There were 25 tablets not accounted for.<br><br>The investigation indicated there were a total of 440 narcotic tablets unaccounted for from November through 12/27/24.<br><br>(continued on next page) |

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| F 0602<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 2/6/25 at 12:17 p.m., the ADON indicated RN 3 had voiced a concern on 12/26/24 that RN 4 had been administering several oxycodones to Resident B. On 12/26/24, Resident B had a card of 8 and a card of 30 oxycodone tablets in the medication cart. On the morning of 12/27/24, the ADON indicated the card of 8 oxycodone tablets was missing. RN 3 had indicated 1 oxycodone had been given out of the card of 8 on the evening of 12/26/24. The 7 left in the card were unaccounted for. She indicated RN 4 would volunteer to come in early to relieve the nurses on the evening shift. When the facility reviewed when she came in early, it was the days the pharmacy was delivering the narcotics that she had ordered. RN 4 would sign for the narcotics and the count sheet and the cards would be missing. RN 4 took the card with 7 of Resident B's oxycodone and the narcotic count record. RN 4 admitted to taking the card and the narcotic count record.<br><br>During a telephone interview with the Corporate RN Consultant on 2/6/25 at 12:28 p.m., she indicated RN 4 had admitted to taking the 7 oxycodone tablets. RN 4 had informed the Police Officer she had been taking the medication over the course of a year. There were over 300 narcotics missing. It was determined RN 4 would order the medications then be at the facility when they were delivered and take the medications along with the narcotic count record or she would sign the medications out and not sign the MAR as given.<br><br>The deficient practice was corrected by 1/3/25 after the facility implemented a systemic plan that included the following actions: law enforcement were notified and responded to the allegation with an investigation, narcotic counts were immediately performed, oriented residents were interviewed to ensure there was no pain or discomfort, and nurses were interviewed. New protocols were initiated to prevent further drug diversion, the Director of Nursing (DON) or the ADON will check the narcotic counts randomly to ensure staff are following the new protocols. When adding narcotic cards to the cart, there must be two signatures and two staff members must sign the delivered narcotic in when delivered by pharmacy. If the narcotic is discontinued, medication card is empty, or the narcotic count record is completed, the DON or ADON will remove the card and the count record. The Narcotics will be counted at the beginning and end of every shift and will be signed by two staff (nurse/QMA). Education has been provided to 12 of the 21 nurses/QMA's and agency staff will be educated when they work. The new protocols are kept in the front the narcotic count binder on each cart. A narcotic count was completed on the 4 of 4 medication carts in the facility and all narcotics were accounted for. Five nurses on day and evening shift were interviewed and were able to describe the new protocols and what to do if there was a discrepancy. They also indicated they would report if a resident was receiving more pain medications than normal. The DON indicated the audits would be continued indefinitely and the results form the audits would be discussed in Quality Assurance meetings.<br><br>This citation relates to Complaint IN00450100.<br><br>3.1-28(a) |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.<br><br>20580<br><br>Based on record review and interview, the facility failed to ensure a 5-Day follow up to a reported incident of misappropriation to the Indiana Department of Health (IDOH) contained thorough and complete information from the facility's investigation of the incident, for 1 of 1 reported incident reviewed.<br><br>Finding includes:<br><br>A Indiana Department of Health (IDOH) reported incident indicated on 12/27/24 at 10:01 a.m., it was reported to the Assistant Director of Nursing and the Administrator, the facility was unable to account for a Resident B's narcotic pain medication or oxycodone 15 mg (milligrams). The Staff involved were RN 3 and RN 4.<br><br>A 5-Day follow-up to the reported incident, dated 1/3/25, indicated the drug diversion was substantiated due to RN 4 admission of taking the oxycodone.<br><br>Cross reference F602.<br><br>The 5-day follow up lacked information from the investigation that indicated two other residents were found to have missing narcotic medication, how many narcotics were unaccounted for, and that RN 3 was not involved in the misappropriation of the medication.<br><br>During an interview on 2/6/25 at 12:17 p.m., Regional [NAME] President indicated the 5-day follow up was missing information found during the investigation.<br><br>This citation relates to Complaint IN00450100.<br><br>3.1-28(e) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident's preferences and goals.<br><br>20580<br><br>Based on observation, interview, and record review, the facility failed to ensure a resident received necessary care and services related to no investigation for the root cause for a resident's multiple skin tears for 1 of 2 residents reviewed for quality of care and skin tears. (Resident C)<br><br>Finding includes:<br><br>During an observation and interviews on 2/5/25 from 8:45 a.m. to 9:42 a.m., CNA 1 and CNA 2 entered Resident C's room to provide care. The resident was observed to have two dressings on the right arm and two dressings on the back of her right hand. CNA 1 indicated the resident had skin tears on her arms.<br><br>Resident C's record was reviewed on 2/5/25 at 11:46 a.m. The diagnoses included, but were not limited to, vascular dementia and diabetes mellitus. The resident was receiving hospice care.<br><br>A Significant Change Minimum Data Set (MDS) assessment, dated 12/10/24, indicated the resident had short and long term memory problems, was dependent for all activities of daily living, had skin tears present, and received hospice care.<br><br>The Wound Report indicated a skin tears were identified on the right forearm and right hand on 1/31/25.<br><br>During an interview on 2/5/25 at 2:30 p.m. the Assistant Director of Nursing (ADON) indicated there were no investigations for the causes of the skin tears. The resident would pick at her skin when she was uncomfortable and there was no care plan with interventions for picking at the skin. The Corporate RN Consultant indicated the skin tears were to be investigated to determine the cause of the tear.<br><br>This citation relates to Complaint IN00451858.<br><br>3.1-37 |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate pressure ulcer care and prevent new ulcers from developing.<br><br>20580<br><br>Based on observation, interview, and record review, the facility failed to ensure a resident's pressure ulcers were assessed thoroughly and timely, the Physician was notified timely of a decline in a pressure ulcer, and an intervention to prevent pressure ulcers was in place, for 1 of 3 residents reviewed for pressure ulcers. (Resident C)<br><br>Finding includes:<br><br>During an observation and interviews on 2/5/25 from 8:45 a.m. to 9:42 a.m., CNA 1 and CNA 2 entered Resident C's room to provide care. When the resident was turned to the right side, there was a large dressing on the left hip with copious amount of bloody drainage that was seeping under the dressing onto the pad underneath the resident and a foul odor was present from the dressing. There was a dressing also observed on the sacral area. At 9:24 a.m., the Assistant Director of Nursing (ADON) entered the room and indicated she was also the Wound Nurse. The ADON indicated she completed wound rounds with the Wound Nurse Practitioner (NP) weekly. Resident C was on hospice and the Wound NP did not see the resident weekly. The ADON completed the wound care and indicated the left hip had two wounds. The ADON estimated the first left hip wound as Length (L) 4 centimeters (cm) by width (W) 3 cm and the second wound was estimated at (L)7 cm by (W) 4 cm with a small area of 0.5 cm depth and slough covering the rest of the wound. The ADON indicated the areas had declined and the odor, drainage, and slough were new to the area. She was just made aware that the treatment to the left hip had been changed and was unsure when the Hospice Nurse changed the treatment orders, as it had not been communicated to her. The ADON indicated the left hip had just been covered with a dressing prior to the calcium alginate (wound treatment for wounds with drainage). A dry dressing was removed from the sacral area. There were two wounds on the sacral area. The ADON indicated both wounds were unstageable due to the necrotic tissue and the areas had declined. She did not complete skin checks and assessments on every resident. The nurses completed weekly skin assessments and were to notify her if there was a concern.<br><br>Resident C's record was reviewed on 2/5/25 at 11:46 a.m. The diagnoses included, but were not limited to, vascular dementia and diabetes mellitus. The resident was receiving hospice care.<br><br>A Care Plan, dated 11/7/24, indicated there was a potential for impairment of the skin. The interventions included, the treatments would be completed as ordered.<br><br>A Re-admission Skin Assessment, dated 12/2/24 at 7:48 p.m., indicated the left buttock had a 3.6 cm by 2.4 cm (length and width was not specified) open area that was superficial.<br><br>A Nurse's Progress Note, dated 12/2/24 at 8:22 p.m., clarified the open area was on the right buttock not the left buttock.<br><br>A Physician's Order, dated 12/2/24, indicated a foam dressing was to be used on the right buttock for protection. The order was discontinued on 12/5/24.<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | A Significant Change Minimum Data Set (MDS) assessment, dated 12/10/24, indicated the resident had short and long term memory problems, was dependent for all activities of daily living, had an indwelling urinary catheter, was frequently incontinent of bowels, had no unhealed pressure ulcers, had skin tears present, and received hospice care.<br><br>A Weekly Skin Assessment, dated 12/16/24 at 9:57 p.m., indicated there was a stage two (partial thickness of skin) wound on the right buttock and the coccyx had fragile skin. There were no measurements of the open area on the right buttock.<br><br>A Weekly Skin Assessment, dated 12/23/24, indicated a stage two area on the right buttock, the coccyx was red, and a protective dressing was used for the right buttock area. The pressure areas were not measured or described.<br><br>A Physician's Order, dated 12/28/24 and discontinued 12/31/24, indicated the sacral area was to be cleansed with soap and water, patted dry and a sacral foam dressing was to be applied for protection on Tuesdays, Thursdays, and Saturdays for skin maintenance.<br><br>A Physician's Order, dated 1/2/25, indicated the sacral area was to be cleansed with soap and water, patted dry, and a sacral foam dressing was to be used for protection. The treatment was to be completed on Tuesdays, Thursdays, and Saturdays for skin maintenance.<br><br>A Weekly Skin assessment, dated 1/3/25 at 5:31 p.m., indicated the right buttock area had a stage two pressure area and a treatment was in place. The coccyx (sacral) area was red and a prophylactic dressing was used for the area.<br><br>There were no Weekly Skin Assessments completed from 12/23/24 to 1/3/25. The right buttock and coccyx areas were not measured or thoroughly described.<br><br>A Weekly Skin Assessment, dated 1/25/25 and completed by RN 3, indicated the right buttock was unstageable (depth of the wound cannot be determined due to eschar or slough) and the sacral area was red. A hydrocolloid dressing was used for the sacral area.<br><br>There were no Weekly Skin Assessments completed from 1/3/25 through 1/25/25. There were no measurements or thorough descriptions of the pressure areas on the 1/25/25 assessment. There was no documentation the Wound Nurse, Physician, and family had been notified of the decline of the right buttock pressure area.<br><br>A Care Plan, dated 1/27/25 and revised on 2/5/25, indicated a pressure ulcer was present on the right buttock. The interventions included the treatment would be completed as ordered.<br><br>The Care Plan did not indicate other pressure ulcers were present.<br><br>A Physician's Order, dated 12/28/25 and discontinued on 1/31/25, indicated the bilateral hips were to be cleansed with soap and water, patted dry and a hydrocolloid (protective dressing) was to applied to the area for protection on every Tuesday, Thursday, and Saturday evening.<br><br>There were no skin assessments of the bilateral hips that indicated there were open areas or the condition of the skin.<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | A Hospice Nurse's Note, dated 1/10/25 at 1:15 p.m., indicated a large stage three (full thickness tissue loss) wound was present on the left hip that had declined from a stage two. The ADON was notified. The wound was cleansed and a foam dressing was applied.<br><br>There was no thorough assessment of the left hip wound that indicated a size and description of the area.<br><br>A Hospice Nurse's Note, dated 1/31/25 at 1:45 p.m., indicated the stage three area on the left hip was observed. There was odorous drainage on the old dressing and no warmth to the area. The facility staff were notified and informed the dressing needed to be changed daily.<br><br>There had been no documentation of changes in the left hip status from 1/10/25 to 1/31/25. The area had not been assessed by the facility.<br><br>A Physician's Order, dated 1/31/25, indicated on 2/1/25, the bilateral hips were to be cleansed with soap and water, patted dry, calcium alginate was to be applied and then covered with a foam dressing daily.<br><br>There were no thorough assessments of the pressure area on the left hip that indicated the size or description.<br><br>A Weekly Skin Assessment, dated 2/4/25 and completed by RN 3, indicated the sacral area was red and a hydrocolloid dressing was used for protection. The right buttock remained unstageable and a treatment was in place.<br><br>There were no measurement or thorough description of the pressure areas on the assessment. There was no assessment of the left hip.<br><br>During an interview on 2/5/25 at 10 a.m., the ADON indicated the Weekly Skin Assessments were to be completed by the nurses and the nurses would either contact her by writing/alert charting or orally about the concerns. The nurses were responsible for obtaining treatment orders. The nurses were not responsible for assessments/staging and measurements. The ADON looked at the wound areas on Thursdays or sooner, if I can get to them, for the initial assessment. She did rounds with the Wound NP on Thursdays and pictures were taken along with the measurements. She did not assess a pressure area unless the area was open. The ADON indicated no one had notified her the resident's left hip area had opened. The Wound NP did not consult on/assess Resident C. She had just seen the calcium alginate order for the left hip this morning.<br><br>During an telephone interview on 2/5/25 at 11 a.m., the Hospice Nurse, indicated she would inform the nurse taking care of the resident of any changes and updates. The pressure areas were unavoidable due to the resident's decline in status and nutrition.<br><br>During an interview on 2/5/25 at 2:30 p.m., the ADON indicated the bilateral hips were not being assessed on the weekly skin assessment. There was no area of concern on the right hip and the order should state the treatment was for the left hip. She indicated there had been no assessments or measurements of the left hip and sacral area completed. The care plan was not correct for the pressure area on the right buttock and the information was taken from the weekly skin assessments.<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 2/5/25 at 2:40 p.m., the ADON indicated there was no open area on the right buttock and the treatment to right buttock had been discontinued 12/5/24<br><br>During an observation on 2/5/25 at 2:52 p.m., the resident was lying in bed, the low air loss mattress was not turned on nor plugged in. The ADON indicated at the time of the observation, she was unsure how long the air flow on the bed had been turned off. There was no pressure area located on the right buttock. The ADON indicated she was unsure why staff were documenting there was an area on the right buttock.<br><br>During a telephone interview on 2/6/25 at 1:28 a.m., RN 3 indicated he had marked the wrong area and there was not an unstageable area on the right buttock. The unstageable area was on the sacral area and was necrotic. The ADON had not been notified, as it was assumed she had already known about the area.<br><br>A facility skin condition assessment policy, dated 6/8/18 and received from the ADON as current, indicated pressure ulcers would be assessed and measured at least weekly by a licensed nurse and documented in the resident's record. The nurse was to observe the wound daily or with dressing changes. Any drainage, redness, pain will be documented in the Nurses' Progress Notes.<br><br>A pressure ulcer policy, dated 1/17/18 and received from the Corporate RN Consultant as current, indicated a wound assessment was to be initiated and documented in the resident's record when a pressure ulcer was identified. Changes in the resident's skin was to be reported to the nurse and the nurse was to perform a detailed assessment. At the earliest sign of a pressure area, the resident, legal representative and the attending physician was to be notified. The initial observation was to be described in the the Nurses' Progress Notes. Pressure area were to be measured at least weekly and recorded in centimeters in the clinical record. The wound assessment was to be completed and to include the site/location, size in length, width, and depth, the stage of the pressure ulcer, odor, drainage, and description.<br><br>This citation relates to Complaint IN00451858.<br><br>3.1-40(a)(2)<br><br>3.1-40(a)(3) |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>20580<br><br>Based on observation, interview, and record review, the facility failed to ensure correct Personal Protective Equipment (PPE) was used by staff members (CNA 1 and CNA 2) when providing care to a resident (Resident C) who was in Enhanced Barrier Precautions (EBP), for two random observations for infection control.<br><br>Finding includes:<br><br>During an observation on 2/5/25 at 8:45 a.m., CNA 1 and CNA 2 entered Resident C's room to provide care. There was a sign on the resident's door which indicated the resident required EBP and there was PPE stored in a container in the hallway. An indwelling urinary catheter was present and CNA 1 indicated the resident had skin tears and pressure ulcers. CNA 1 and CNA 2 wore gloves and no gowns. They were stopped prior to starting care. CNA 1 and CNA 2 indicated they should have a gown on while providing care.<br><br>During an observation on 2/5/25 at 11:49 a.m., CNA 2 and LPN 5 were at Resident C's bedside and was repositioning the resident in bed. They wore gloves. They were not wearing a gown. LPN 5 indicated EBP PPE should have been worn during care.<br><br>Cross reference F684.<br><br>A EPB facility policy, dated 5/7/24 and received from the Corporate RN Consultant as current, indicated EBP was to be utilized for residents with chronic wounds and/or indwelling catheters.<br><br>3.1-18(b) |