STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155587	A. Building B. Wing	05/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aperion Care Summerfield	34 South Main Street Cloverdale, IN 46120

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48226 Based on record review and interview, the facility failed to ensure the code status of a resident was accurate for the physician order, careplan, and POST (physician's order for scope of treatment) form for 1 of 17 records reviewed. (Resident 24) Findings include: On [DATE] at 11:21 a.m., the medical record of Resident 24 was reviewed. The resident was admitted to the facility on [DATE]. Admitting diagnosis included but not limited to Huntington's Disease (a progressive inherited brain disorder that causes uncontrolled movements, cognitive decline, and psychiatric symptoms), anxiety (a feeling of fear, dread, and uneasiness. It might cause you to sweat, feel restless and tense, and have a rapid heartbeat. It can be a normal reaction to stress) and dysphagia (difficulty swallowing). A physician order, dated [DATE], indicated that the resident chose to be a full code (to provide full resuscitation in the event of the need for life saving measures). A POST form (Physician Orders for Scope of Treatment form is a standardized document that allows patients with advanced chronic or terminal illnesses to document their specific treatment preferences for end-of-life care), dated [DATE], indicated that the resident chose to be a DNR (Do Not Resuscitate). The form had been updated from full code on the previous POST form to administer CPR. A quarterly Minimum Data Set (MDS) assessment, dated [DATE], indicated that the resident was cognitively impaired. A care plan, dated [DATE], indicated per the Power of Attorney (POA) for healthcare and per resident, the resident signed a valid DNR which indicated Do Not resuscitate should I stop breathing, display no pulse as a result of failure of the heart to contract effectively or at all. On [DATE] at 1:00 p.m., during interview the Administrator indicated the resident was to be a DNR and the POST form currently in the medical record was correct and the physician order was incorrect. On [DATE] at 9:47 a.m., during interview Licensed Practical Nurse (LPN) 6 indicated she would look for the most recent POST form to verify code status. She indicated the resident's status changes often and updates were recorded in the medical record. (continued on next page)

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
	155587	A. Building B. Wing	05/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aperion Care Summerfield	34 South Main Street Cloverdale, IN 46120

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 12:54 p.m., the Administrator provided a document, titled, Advanced Directives, dated [DATE], and indicated it was the policy currently being used by the facility. The policy indicated, . 8. If a resident or healthcare representative indicates an Advanced Directive regarding CPR or scope of treatment (POLST or POST) the appropriate forms will be completed. 9. A written physician's order is required in response to the resident's Advanced Directive(s). Physician's orders shall be specific and address each advanced Directive(s) 3XXX,d+[DATE](d)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155587	A. Building B. Wing	05/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aperion Care Summerfield	34 South Main Street Cloverdale, IN 46120

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. 35317 Based on interview and record review, the facility failed to ensure the accuracy of a Minimum Data Set (MDS) assessment for 1 of 11 residents MDS assessments reviewed (Resident 32). Findings include: During an interview, on 4/30/25 at 9:57 a.m., Resident 32 denied that she had a feeding tube for nutritional intake. She indicated that she had never had one. Resident 32's record was reviewed on 5/2/25 at 9:02 a.m. The profile indicated the resident's diagnoses included, but were not limited to, Huntington's disease (an inherited condition in which nerve cells in the brain break down over time), dysphagia, unspecified (refers to medical term for difficulty swallowing), and nutritional deficiency (lack of sufficient nutrients in the body). A quarterly MDS assessment, dated 4/25/25, indicated the resident had a feeding tube (a medical device used to deliver nutrition and fluids directly into the digestive system, bypassing the mouth and esophagus). A physician order, dated 10/7/24, indicated a regular diet, mechanical soft (foods that have been altered in texture to make them easier to chew and swallow) thick liquids consistency. A care plan, dated 10/11/24, indicated the resident had alteration in nutrition related to Huntington's disease. Interventions included, but were not limited to, honor food preferences, encourage good intake, and notify medical doctor of significant weight changes. During an interview, on 5/5/25 at 9:50 a.m., the MDS Coordinator indicated there was a coding error on Resident 32's quarterly MDS assessment and she would need to go in and modify it. She indicated the resident never had a feeding tube. During an interview, on 5/5/25 at 9:52 a.m., the Administrator indicated it was a possibility the Dietary Manager marked the wrong box on the MDS assessment. The MDS assessment had been coded wrong and needed to be modified. Section K of the CMS (Centers for Medicaid and Medicare Services) RAI (Resident Assessment Instrument) Version 3.0 Manual, dated October 2024, indicated.N0520: Nutritional Approaches: Check all of the following nutritional approaches that apply: .3. while a resident .B. Feeding tube .Steps for Assessment: Review the medical record to determine if any of the listed nutritional approaches were performed during the look-back period .check all that apply .K0520B, feeding tube .Coding tip for K0502B: only feeding tubes that are used to deliver nutritive substances and or hydration during the assessment period are coded in K0502B 3.1-31(c)(5)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155587	A. Building B. Wing	05/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aperion Care Summerfield	34 South Main Street Cloverdale, IN 46120

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48226 Based on record review and interview, the facility failed to ensure quarterly care plan meetings, which addressed the specific needs of the Resident were completed for 1 of 16 residents reviewed (Resident 29). Findings include: On 5/1/25 at 9:32 a.m., during an initial interview, Resident 29 did not recall attending care plan meetings which addressed his specific needs. On 5/1/25 at 1:00 p.m., the medical record of Resident 29 was reviewed. The resident was admitted to the facility on [DATE]. Diagnosis included but not limited to Huntington's Disease (a progressive inherited brain disorder that causes uncontrolled movements, cognitive decline, and psychiatric symptoms), and epilepsy (a disorder of the brain characterized by repeated seizures). An annual Minimum Data Set (MDS) assessment, dated 3/15/25, indicated the resident was cognitively impaired. A comprehensive care plan addressing the resident's needs, initiated on 3/27/24, was reviewed and updated accordingly. The medical record lacked documentation of a quarterly care plan meeting or of the resident being notified and offered to attend. On 5/1/25 at 10:00 a.m., during an interview the Social Services Director indicated the facility had regular care plan meetings with the resident and the resident's responsible party were invited to attend. On 5/2/25 at 10:30 a.m., during interview the Administrator indicated the resident had several care plan meetings with the Social Services Director and the resident did attend. She acknowledged the documentation did not reflect a specific care plan meeting addressing all needs. She indicated the meetings they had with the resident had been regarding his desire for more freedom and ability to pursue intimacy. On 5/2/2025 at 10:38 a.m., the Administrator provided a document, titled, Comprehensive Care Plan, dated 11/28/12, and indicated it was the policy currently being used by the facility. The policy indicated, .A comprehensive care plan must be .To the extent practicable, the participation of the resident and the resident's representative (s). An explanation should be included in a resident's medical record .Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments .The resident and or resident representative shall be invited to review the plan of care with the interdisciplinary team either in person , via telephone or video conference (if available) at least quarterly 3.1-35(c)(1)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155587	A. Building B. Wing	05/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aperion Care Summerfield	34 South Main Street Cloverdale, IN 46120

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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. 48226 Based on observation and interview, the facility failed to ensure water temperatures in the dining room wash station and common restrooms were within safe parameters for 3 of 3 random observations. Findings include: On 4/30/25 at 11:51 a.m., while observing the staff washing their hands during meal service, noted the water was very hot and staff had to continually adjust the water. The water temperature was 143 degrees in the main dining room kitchen sink. During two observations one at 10:00 a.m. and again at 2:05 p.m., the door to the common restroom on the south hall was unlocked. The water temperature was 135.5 degrees. During observation of the south hall resident room and shower room indicated, the water temperature in the south hall shower and sink was 119 degrees. Resident rooms on both halls observed water temperatures were within acceptable parameters. On 4/30/25 at 2:39 p.m., during interview the Administrator indicated the water in the employee restroom was connected to the main kitchen. She was not aware the door was unlocked and indicated a visitor must have left it unlocked. She indicated the small dining kitchen serving area had a latch on the half door preventing residents from entering into the area. She indicated the water was set to the current temperature so they could prepare hot drinks and did not think it was too hot for the employees. She indicated she was advising the Maintenance Director to turn the temperature down. The Administrator provided water temperature logs indicating water temperatures in the resident rooms was within acceptable parameters. On 5/1/2025 at 12:54 p.m., the provided an undated document, titled, Domestic Water Temperature, and indicated it was the policy currently being used by the facility. The policy indicated, .Temperatures of water coming out of sink faucets and showers should be between 100-120 degrees F to prevent 3.1-45(a)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155587	A. Building B. Wing	05/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aperion Care Summerfield	34 South Main Street Cloverdale, IN 46120

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 35317 Based on observation, interview, and record review, the facility failed to ensure proper handwashing for 1 of 2 dining observations. Findings include: 1. During a dining observation, on 4/30/25 at 11:55 a.m., Dietary Aide 5 turned on the water faucet and obtained soap onto her hands, she proceeded to adjust the water temperature by touching the faucet handles with her bare hands, she washed her hands for 10 seconds and turned off the water faucet with her bare hands, obtained a paper towel and dried her hands. She proceeded to a table and adjusted a resident in their wheelchair, so she was closer to the table. 2. During a dining observation, on 4/30/25 at 11:56 a.m., Dietary Aide 5 turned on the water faucet and obtained soap onto her hands, she proceeded to adjust the water temperature by touching the faucet handles with her bare hands, she washed her hands for 10 seconds and turned off the water faucet with her bare hands, obtained a paper towel and dried her hands. She proceeded to wait at the counter for the lunch trays to be ready to be served, pulled on the back of her t-shirt and placed her hands behind her back. 3. During a dining observation, on 4/20/25 at 12:20 p.m., Dietary Aide 4 washed her hands for 5 seconds and turned off the water faucet with her bare hands, obtained a paper towel and dried her hands. She proceeded to the serving counter and served 3 bowls of cereal to residents. 4. During a dining observation, on 4/30/24 at 12:21, Dietary Aide 5 turned on the water faucet and obtained soap onto her hands, she proceeded to adjust the water temperature by touching the faucet handles with her bare hands, she washed her hands for 10 seconds and turned off the water faucet with her bare hands, obtained a paper towel and dried her hands. She proceeded to the serving counter and obtained a lunch tray to serve to a female resident. During an interview, on 4/30/25 at 2:58 p.m., the Assistant Director of Nursing (ADON) indicated she had noted there were some concerns identified during meal service today related to handwashing. She indicated the staff was observed to not be washing hands for the appropriate amount of time and not the correct technique. During an interview, on 4/20/25 at 3:05 p.m., the Administrator indicated they had provided a hand hygiene in-servicing to staff today after improper technique was noted during the lunch meal service. During an interview, on 5/5/25 at 10:34 a.m., Housekeeping Aide 7 indicated staff should wash their hands for approximately 1 minute, obtain a paper towel to turn off the faucet and then obtain a second paper towel to dry your hands. She further indicated staff should not touch the water faucet with bare hands. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155587	A. Building B. Wing	05/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aperion Care Summerfield	34 South Main Street Cloverdale, IN 46120

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/30/25 at 3:05 p.m., the Administrator provided an undated document, titled, Hand Washing, and indicated it was the policy currently being used by the facility. The policy indicated, .2. Apply soap, using friction rub hands together, cleaning under nails and between fingers thoroughly and up to wrist for 20 seconds. 3. Rinse hands well without touching the inside of sink or faucet. 4. Dry hands well with paper towel. Use clean paper towel to turn off faucet. Discard paper towel in trash receptacle 3.1-21(i)(3)