| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155799 | A. Building<br>B. Wing | 09/30/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Aperion Care Marion LLC | 614 West 14th Street<br>Marion, IN 46953 |

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 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>(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 |
|---|---|---|
| | | |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Based on observation, interview, and record review, the facility failed to ensure a resident was free from verbal abuse and intimidation by a staff member for 1 of 3 residents reviewed for abuse. (Resident C)Findings include:Resident C's clinical record was reviewed on 9/29/25 at 12:10 p.m. Diagnoses included chronic obstructive pulmonary disease (COPD), hypertension, depression, atrial fibrillation, and congestive heart failure.An admission Minimum Data Set (MDS) assessment, dated 8/4/25, indicated Resident C was cognitively intact, had depression, required supervision for bed mobility, transfers, toileting, and eating. Resident C did not exhibit hallucinations, delusions, or behaviors.A current care plan, initiated on 7/30/25, indicated Resident C had a diagnosis of depression. Interventions included administering medications as ordered, encouraging socialization, and observing signs and symptoms of depression (crying, seclusion from others, isolation, decreased appetite, withdrawal).A current care plan, initiated on 9/22/25, indicated Resident C used antidepressant medication related to diagnoses of anxiety and depression. Interventions included administering medications as ordered and monitoring for side effects and effectiveness every shift, educating the resident/family/caregivers about the risks, benefits, and side effects of medications, and monitoring/documenting/reporting, as needed, adverse reactions to antidepressant therapy.A progress note, dated 9/26/25 at 1:56 p.m., indicated the Social Services Director (SSD) spoke with Resident C about the situation that occurred in the dining room. The SSD conducted a psychosocial assessment along with an abuse/neglect screening. Psychological services were scheduled to follow up with the resident on 10/1/25. Review of a facility - reported incident indicated, on 9/25/25, Resident C, was attempting to get a drink in the dining room, and was approached by Dietary Aide (DA) 3, who informed Resident C he was not allowed to get his own drink from the drink cart. An exchange of words between Resident C and DA 3 ensued and ended with DA 3 telling the resident he would knock his dumb f****ing a** out. The resident was removed from the situation, and the incident was reported to the Dietary Manager (DM).A written statement by DA 3, signed and dated 9/25/25, provided by the Administrator (ADM) on 9/29/25 at 12:30 p.m., indicated upon service to residents in the dining room, a particular resident, Resident C, approached the cooking area and began serving himself. DA 3 told the resident that he wasn't allowed to do so, and the resident began ranting at him. DA 3 may have responded in an unprofessional manner.During an interview with the Dietary Manager (DM) on 9/29/25 at 2:17 p.m., he indicated he had just arrived at the facility when DA 3 approached him about the incident. DA 3 described how Resident C was behind the counter getting himself a drink. DA 3 approached the resident and told him he could not be back there. The conversation escalated into a back-and-forth confrontation. The DM wrote up DA 3 and went to Human Resources (HR) to report the incident. The DM indicated other staff were present when the altercation took place, but nobody heard what was said. During an interview with [NAME] 2 on 9/30/25 at 10:22 a.m., he indicated he heard DA 3 talking to himself at the service window and could tell DA 3 was mad about something. [NAME] 2 was not paying attention to Resident C at that time. Later in the day, DA 3 told [NAME] 2 about Resident C getting his own drinks and passing coffee out to other residents. DA 3 just wanted to do his job.During an interview with Resident C on 9/30/25 at 10:07 a.m., he indicated DA 3 said he would knock me out. There were residents and other dietary staff present at the time of the incident. DA 3 started running his mouth and told Resident C if he did not quit talking, he was going to knock him out. Resident C walked away, but DA 3 followed him and continued to threaten him. That was not the first time DA 3 was disrespectful to Resident C.During an interview with DA 3 on 9/30/25 at 11:36 a.m., he indicated Resident C became unruly during breakfast service. He cut into the line and got his own drink. DA 3 had told him several times previously he was not allowed behind the service line. DA 3 felt Resident C was being disrespectful to the dietary staff. DA 3 indicated he might have been a little loud when addressing Resident C. He reported the incident to the DM and was suspended pending an investigation. He was later terminated. He felt Resident C's statement was respected over his own statement regarding the incident.During an interview with the Administrator on 9/30/25 at 11:55 a.m., she indicated Resident C said DA 3 cursed at him, saying I'll knock your f***ing a** out. DA 3 indicated to both the Administrator and the DM Yeah, I probably did say that. Resident C did not have a history of being dishonest. DA 3 indicated he yelled at Resident C the day before when passing him outside, in front of the facility. DA 3 and Resident C had a history outside of the facility, prior to either being affiliated with the facility.During an interview with the DM on 9/30/25 at 12:17 p.m., he indicated DA 3 was waiting in the back parking lot the morning of the incident. DA 3 asked Resident C to not get his own drinks |