STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155799	A. Building B. Wing	02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aperion Care Marion LLC	614 West 14th Street 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 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. Based on interview and record review, the facility failed to identify the risk for the development of wounds and failed to develop and implement interventions to prevent wounds for 1 of 3 residents reviewed for wounds. (Resident B) This deficient practice resulted in the resident requiring hospitalization and surgical intervention to treat a severely infected diabetic ulcer to their foot.Findings include:An anonymous report submitted to the Indiana Department of Health indicated Resident B had developed a wound to his foot the facility failed to notice and then had blamed the resident of causing it by using nail clippers to cut his skin.Resident B's clinical record was reviewed on 2/25/26 at 9:44 a.m.A nurse practitioner progress note, dated 2/16/26, for a follow up related to a urinary tract infection indicated the resident's family member approached the nurse's station demanding that someone examine the resident's left foot. The nurse practitioner and the facility nurse entered the resident's room and noted a wound to the bottom of the resident's left foot. His left forefoot had a circular necrotic hard, firm, wound with pink granular tissue and peeling skin, measuring 5 centimeters (cm) length by 4.5 cm width with no depth. A second area of darkened skin was noted along his heel. A third area on his left third toe had a darkened area along nail. A fourth area with darkened skin along the lateral nail and the dorsal foot was erythemic (red in color), cool to touch and non-tender. A duplex scan (ultrasound study) of the venous systems of his left lower extremities was completed on 2/16/26 due to swelling. The impression indicated that there was no evidence of deep venous thrombosis (blood clots). The nurse practitioner's plan was to obtain a STAT (immediate) x-ray of his left foot to rule out osteomyelitis and a STAT complete blood count (CBC) lab, and wound care per facility policy. The resident was observed sitting up in wheelchair after the treatment of his foot was completed, and he used his barefoot to propel himself in his wheelchair. He was educated to attempt to not utilize bare feet to move his wheelchair. The nurse practitioner assisted the resident with putting socks on and requested a protective boot to be placed. The duplex scan results were normal and without evidence of deep venous thrombosis. A nurse's note, dated 2/16/26 at 1:55 p.m., indicated the nurse practitioner saw the resident related to edema (swelling) and an abrasion (top layer of skin rubbed off) to his left foot. New orders were received for STAT CBC, x-ray to his left foot, doppler to left extremity, midline (intravenous line) to be placed for IV antibiotic STAT, discontinue Macrobid (antibiotic) and start Zosyn. A left heel wound assessment, dated 2/16/26, indicated he had a facility acquired abrasion that was 100% necrotic (darkened, dead tissue) area that measured 2 cm length by 1.5 cm width with no depth. A new order was received to apply skin protectant every shift. A left plantar (bottom of) foot wound assessment, dated 2/16/26, indicated he had a facility acquired abrasion that had 40% pink or red non-granulating tissue with 60% hard, firm adherent necrotic tissue that measured 5 cm length by 4.5 cm width with no depth. It appeared that the resident had been picking at the wound and cutting the surrounding tissue. A new order was received to paint the wound with povidone iodine and cover with a foam border daily. A physician's progress note, dated (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 - Actual harm Residents Affected - Few	2/17/26, indicated the resident was seen related to a foot wound with concerns for osteomyelitis. The x-ray results showed soft tissue swelling and bone irregularity in his great toe. He had a prior fourth and fifth toe amputation. The physician's plan was to have a Magnetic Resonance Imaging (MRI) completed to rule out osteomyelitis and a prior authorization from insurance was pending. The resident would be started on vancomycin and Zosyn for presumed osteomyelitis while awaiting MRI approval.A nurse practitioner progress note, dated 2/18/26, indicated the resident was seen for a follow up visit related to possible osteomyelitis. He was observed sitting up in his room in his wheelchair using his foot to move wheelchair and was not wearing his heel boot as ordered. He was started on IV Zosyn (antibiotic) and vancomycin and reported hearing loss. Per nursing, he was not compliant with wearing the boot and was observed propelling wheelchair with his affected foot. The nurse practitioner's plan was a pending MRI to rule out osteomyelitis. The resident was offered to go to the hospital for an evaluation and treatment, which the resident adamantly refused. Vancomycin was discontinued and Zyvox 600 mg IV every 12 hours for 14 days was added. After the assessment and discussion with the resident regarding hospitalization, his family arrived demanding that the resident to be sent to the emergency room (ER) for evaluation.The hospital's operative procedure notes, dated 2/19/26, indicated that an incision was performed on the left foot and drainage of an abscess (painful, inflamed pocket of pus) in deep tissue, abscess surrounding the tendon (connective tissue) and septic arthritis (severe joint infection), second Metatarsophalangeal Joint (a joint in the foot).During an interview, on 2/25/26 at 4:02 p.m., LPN 13 indicated Resident B's family member reported there was an area on the bottom of the resident's left foot, approximately the size of a tennis ball and a DTI to his heel. The area had black, hard, necrotic tissue and looked like the thick skin that once covered the necrotic area was torn, cut, or peeled back with either scissors or nail clippers. Resident B did not complain of pain, but there was edema to his lower extremities. LPN 13 had not seen Resident B with scissors or nail clippers. He was very mobile and used a wheelchair for mobility. He was able to transfer from his bed to his wheelchair with assistance. He wore socks, shoes, non-skid socks, or slippers. He was able to apply his shoes himself.During an interview, on 2/26/26 at 1:47 p.m., Nurse Practitioner 8 indicated, on 2/16/26, Resident B's family member approached the nurse's station and reported that something was wrong with Resident B's leg. When Nurse Practitioner 8 entered Resident B's room, his sock was off and it looked like the wound had been trimmed. Previously, the resident had picked at various scabs, but she had never witnessed him having scissors or nail clippers. He normally wore gripper socks and propelled himself with his feet, not his hands on the wheels. Nurse Practitioner 8 ordered Resident B an antibiotic, an ultrasound for his leg to rule out a deep vein thrombosis (DVT) (blood clot), an x-ray of his foot, and labs. He was offered to be sent to the hospital earlier in the day on 2/18/26 and he did not want to go. Later that day, the facility called her and the family of Resident B demanded for the resident to be sent to the hospital. Nurse Practitioner 8 sent him out due to needing an MRI for his foot and his family demanding him to go.During an interview on 2/26/26 at 3:04 p.m. CNA 5 indicated Resident B, at times, was able to put on socks and shoes. She assisted him with washing his body in the shower, but he was able to wash his private areas. He refused to shower on 2/13/26. She looked at his feet and there were no concerns, no redness, and only a scab where his toe used to be. There was nothing on the ball of his foot and no bruising or redness. Review of Resident B's clinical record indicated diagnoses included vascular dementia, hemiplegia and hemiparesis following other nontraumatic intracranial hemorrhage affecting right non-dominant side, dependence on supplemental oxygen, type 2 diabetes mellitus without complications, morbid (severe) obesity due to excess calories, chronic respiratory failure, chronic diastolic (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	(congestive) heart failure, chronic obstructive pulmonary disease (COPD), other idiopathic peripheral autonomic neuropathy, acquired absence of other right toe(s), and acquired absence of other left toe(s). An 11/15/25, quarterly, Minimum Data Set (MDS) assessment indicated he was cognitively intact. He was at risk for the development of pressure ulcers and he had pressure reducing devices to his chair and bed. Current physician's orders included sugar free oral supplement (nutritional supplement to promote wound healing) 30 milliliters (ml) twice daily for wound care, vancomycin (antibiotic) intravenously (IV) 1000 mg (milligram)/200 ml every 12 hours for osteomyelitis (bone infection), Zyvox (antibiotic) IV 600 mg/300 ml every six hours for osteomyelitis for 14 days, Magnetic Resonance Imaging (MRI) with contrast of left foot one time only for osteomyelitis, and skin protectant to left heel every shift for wound care.Current care plans included the following:Potential for skin impairment (initiated on 4/9/22) related to vascular dementia, dependence on supplemental oxygen, major depressive disorder, gout, anemia, muscle spasms, hemiplegia and hemiparesis, diabetes mellitus, convulsions, absence of left and right toes, benign prostatic hyperplasia, morbid obesity, obstructive and reflux uropathy, and being noncompliant with care. Interventions included minimize pressure over boney prominences (4/11/22).Non-compliant/resistive to care (initiated on 2/1/24) for refusing mediations, oxygen therapy, shower/bed baths, and oral supplement.The clinical record lacked indication the resident picked at his skin or used implements to cut his skin or wounds.A Braden Scale assessment (predicts pressure injury), dated 1/10/26, indicated that he was not at risk for developing pressure injuries. A Weekly Skin Observation note, dated 2/7/26 at 1:58 a.m., indicated his skin was warm, dry, and intact and within normal limits with good skin turgor. No foot concerns were noted. A functional abilities progress note, dated 2/13/26, indicated he required partial to moderate assistance with bathing, lower body dressing and putting on and taking off footwear. A shower sheet document, dated 2/13/26, indicated that he refused his shower because he did not feel good and a full body check was completed. A nurse's note, dated 2/13/26 at 4:55 p.m., indicated that he wasn't feeling well enough to shower and signed a refusal of shower form.A late entry weekly skin observation note, dated 2/14/26 at 11:40 p.m. and written on 2/19/26 at 6:41 p.m., indicated his skin was warm, dry, flaky and within normal limits. He refused his shower and the skin assessment with the shower, so his feet were not assessed. He had calloused areas to his feet prior to this date.A current facility policy, titled Pressure Injury and Skin Condition Assessment, and provided by the DON on 2/26/26 at 3:11 p.m. indicated the following: .4. Each resident will be observed for skin breakdown daily during care and on the assigned bath day by the CNA. Changes shall be promptly reported to the charge nurse who will perform the detailed assessment.This citation relates to Intake 2749190. 410 IAC (Indiana Administrative Code) 16.2-3.1-37(a)

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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. Based on record review and interview, the facility failed to develop and implement individualized interventions to mitigate the risk of pressure injuries for a resident experiencing decreased mobility while recovering from a hip fracture for 1 of 3 residents reviewed for pressure injuries. (Resident E)Findings include:Resident E's clinical record was reviewed on 2/26/26 at 8:56 a.m. Diagnoses included chronic combined systolic (congestive) and diastolic (congestive) heart failure, end stage renal disease, dependence on renal dialysis, presence of automatic (implantable) cardiac defibrillator, encounter for other orthopedic aftercare, displaced intertrochanteric fracture of right femur, subsequent encounter for closed fracture with routine healing, muscle wasting and atrophy, not elsewhere classified, multiple sites, and other abnormalities of gait and mobility.Current physician's orders included sugar free nutritional supplement (promotes wound healing) 30 milliliters (ml) twice daily, nutritional supplement three times daily, dialysis friendly nutritional supplement three times daily if he did not consume meals, and skin protectant every shift.A 1/27/26 admission Minimum Data Set (MDS) assessment indicated he was cognitively intact. He was at risk of developing pressure ulcers/injuries. He had a surgical wound. And he had pressure-reducing devices for his chair and bed. He had an impairment to one side of his lower extremities. He used a manual wheelchair for mobility.A current care plan indicated the potential for skin impairment (initiated on 1/25/26) related to an encounter for other orthopedic aftercare, displaced intertrochanteric fracture of right femur, abnormalities of gait and mobility, muscle wasting and atrophy. Interventions included minimize pressure over boney prominences (1/25/26).The clinical record lacked individualized interventions to prevent or mitigate the risk of pressure injuries.A shower sheet, dated 2/5/26, indicated he received a shower and a full body check was completed.A weekly skin observation note, dated 2/6/26 at 3:10 a.m., indicated his skin was warm and dry with good skin turgor. He had a right trochanter (hip) surgical incision with staples removed and wound closure strips were intact. It was noted that there were no foot concerns.A Braden Scale assessment (for pressure injury risk), dated 2/6/26, indicated he was at risk for developing pressure injuries.A shower sheet dated 2/9/26 indicated he received a shower. The form lacked documentation of a skin check.A weekly skin observation, dated 2/13/26 at 1:50 a.m., indicated an open lesion was observed on the resident's foot, a small open area to the back of his right heel. A treatment was in place. The skin concerns observed to his feet were not new.A facility acquired ulceration wound assessment, dated 2/23/26, indicated he had a DTI (serious type of pressure injury with dark, purple or maroon skin or intact blood-filled blister) to his right heel that was identified on 2/9/26. The DTI was 100% necrotic (darkened, dead tissue), hard, and measured 6 cm length by 6 cm width (the size of a large egg), with no depth. During an interview, on 2/26/26 at 12:14 p.m., the ADON indicated Resident E's DTI was initially reported by the therapy department. Therapy asked the ADON to look at it and it was an obvious DTI. On admission, Resident E had a surgical incision, which was on the same side of his body as the DTI. The resident did not have pressure relief boots implemented when the DTI was noticed. The facility standards were to turn and reposition the residents every two hours and as needed, float (raise) heels, and offload prominent areas. CNAs completed shower sheets, reported excoriation or redness, the nurse assessed the resident, and reported to the ADON. The nurses were responsible for completing weekly skin assessments.During an interview, on 2/26/26 at 3:43 p.m., Physical Therapist 5 indicated she was applying socks to Resident E's feet and noticed an area on his right heel. She compared his heels and reported it to the nurse.A current facility policy, titled Pressure Injury and Skin Condition Assessment, and provided by the DON on 2/26/26 at 3:11 p.m. indicated the following: .4. Each resident will be observed for skin breakdown daily during care (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and on the assigned bath day by the CNA. Changes shall be promptly reported to the charge nurse who will perform the detailed assessment.A current facility policy, titled Pressure Injury Prevention, and provided by the DON on 2/26/26 at 3:11 p.m. indicated the following: .Guidelines.2. Inspect the skin several times daily during bathing, hygiene, and repositioning measures.11. Use positioning devices or pillows, rolled blankets, etc. to reduce pressure and friction/shearing from heels, toes, and malleoli as indicated.This citation relates to Intake 27491090. 410 IAC (Indiana Administrative Code) 16.2-3.1-40(a)(1)