STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155799	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/01/2024
NAME OF PROVIDER OR SUPPLIER: Aperion Care Marion LLC		STREET ADDRESS, CITY, STATE, ZIP CODE: 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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. 45122 Based on observation, interview, and record review the facility failed to obtain physician orders for medications and assess residents for self-administration of medications for 2 of 2 residents with medications stored in their rooms. (Resident 35 and Resident 52) Findings include: 1. During an observation, on 6/24/24 at 11:38 a.m., a mometasone furoate nasal spray (used to treat and prevent symptoms of seasonal and perennial hay fever) was on Resident 52's bedside table. Resident 52 indicated she gave herself a spray in each nostril in the morning and evening. During an observation, on 6/26/24 at 12:41 p.m., the nasal spray remained on the resident's bedside table. During an observation, on 6/27/24 at 2:37 p.m., the nasal spray remained on the resident's bedside table. Resident 52's clinical record was reviewed on 6/25/24 at 2:19 p.m. and lacked a physician's order for mometasone furoate spray and a self-administration of medication assessment. During an interview, on 6/27/24 at 3:57 p.m., LPN 8 indicated the residents were permitted to have medications in their rooms if there was a may keep at bedside order (MKABS). The resident must also be assessed to see if they met criteria for a MKABS order. The family had probably brought in the nasal spray for the resident. During an interview, on 6/28/24 at 11:22 a.m., LPN 7 indicated for residents to keep medications in their room, they must have a MKABS order and have an assessment completed that determines they meet criteria to self-administer medications. During an interview, on 6/28/24 at 5:06 p.m., the DON indicated residents should not have medications in their rooms unless they have a MKABS order and a self-administration assessment completed indicating the resident meets criteria for self-administration of medications. (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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. During an observation, on 6/25/24 at 10:26 a.m., Resident 35 had a tube of nystatin triamcinolone ointment (for fungal skin infections) setting in a cup holder on her recliner and an albuterol sulfate inhaler placed on her bedside table. Resident 35 indicated the inhaler was her rescue inhaler, and the staff had left the cream in her room for her to apply herself as she needed. During an observation, on 6/27/24 at 9:59 a.m., the resident was assisted back to her room by a staff member. The albuterol inhaler remained on her bedside table. The nystatin cream remained in the cup holder portion of her recliner. Resident 35's clinical record was reviewed on 6/26/24 at 9:23 a.m. She had a current physician's order for albuterol sulfate HFA Aerosol Solution 108 (90 Base) MCG/ACT 2 puff inhale orally every 4 hours as needed for SOB, unsupervised self-administration, may keep at bedside (12/13/23). She lacked an order for nystatin triamcinolone cream. The clinical record lacked a self-administration of medication assessment. During an interview, on 6/27/24 at 3:57 p.m., LPN 8 indicated the resident had a MKABS order for her albuterol inhaler. She did not have an order for the nystatin triamcinolone and should not have it in her room. During an interview, on 6/28/24 at 5:06 p.m., the DON indicated the residents should not have medication in their rooms unless they had a MKABS order and a self-administration of medication assessment completed. The nurses were to complete a self-administration of medication assessment to see if a resident met criteria when a MKABS ordered was obtained. She was unable to locate a self-administration of medication assessment for Resident 35. A current, undated facility policy, provided by the Administrator on 7/1/24 at 4:34, titled Self-Administration of Medication, indicated the following: .A resident may not be permitted to administer or retain any medication in his/her room unless so ordered, in writing, by the attending physician .b. Only medications permitted for self-administration shall be left at the bedside; c. A self-administration of medications assessment will be completed that indicates that the resident is capable of self-administering drugs 3.1-11(a)

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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. 45122 Based on interview and record review, the facility failed to ensure advance directives were developed and signed by the resident, who was cognitively intact and their own representative, for 1 of 2 residents reviewed for advance directive. (Resident 35) Findings include: Resident 35's clinical record was reviewed on 6/26/24 at 9:23 a.m. Diagnoses included unspecified adrenocortical insufficiency (Addison's disease), epilepsy, unspecified, not intractable, without status epilepticus, and cirrhosis of liver. Current physician's orders included full code (9/7/23). An admission Minimum Data Set (MDS) assessment, dated 9/9/23, indicated the resident was cognitively intact. An Indiana Physician Orders for Scope of Treatment (POST) form was completed on 9/7/23. Section E indicated in order for the POST form to be effective the patient or legally appointed representative must sign and date the form. Under the signature of patient or legally appointed representative section, the resident's representative had signed the form on 9/7/23. The resident's profile indicated the resident was the responsible party and the health care decision maker. The resident's record lacked documentation of a guardian, a health care representative, or a power of attorney. During an interview, on 7/1/24 at 2:28 p.m., the DON indicated when the resident came into the facility, her family accompanied her and signed some of the paperwork. She was uncertain why the POST would have been signed by her representative instead of the resident. She indicated Social Services should know about it. During an interview, on 7/1/24 at 3:09 p.m., the Social Services Director indicated she did not go over advance directives with the residents and their families. The nursing department was responsible for ensuring the advance directives were completed. During an interview, on 7/1/24 at 3:42 p.m., the Administrator indicated she was uncertain who completed the advance directives with the residents and their representatives. During the same interview, the Business Office Manager (BOM) indicated the nursing department assisted the residents and their representatives with advance directives, then the ADON reviewed the advance directives. During an interview, on 7/1/24 at 3:45 p.m., the BOM indicated the resident lacked documentation on file for a guardian, healthcare representative, or power of attorney. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview, on 7/1/24 at 4:30 p.m., the ADON indicated she collected the advance directives and made sure the orders matched the signed advance directives. The resident cried a lot when she was admitted to the facility, so the resident representative may have signed for her. A current facility policy, revised 8/14/18, provided by the Administrator on 7/1/24 at 4:34 p.m., titled Advance Directives indicated the following: .If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. 5. The facility will provide this information to the individual once he or she is able to receive such information. This will be determined by Social Service and/or attending physician assessment of the resident to determine if the resident is capable of understanding and is able to make a decision regarding advance directives .7. A resident who has not been declared legally incompetent or found by their attending physician to be capable of making a decision may exercise the right to participate in decision making concerning their health care and medical treatment 3.1-4(f)(7)

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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. 45122 Based on record review and interview, the facility failed to accurately code medications on the Minimum Data Set (MDS) assessments for 1 of 3 residents reviewed for medication use. (Resident D) Finding includes: Resident D's clinical record was reviewed on 6/25/24 at 4:12 p.m. Diagnoses included depression, delusional disorders, hallucinations, unspecified, vascular dementia, moderate, with agitation, and atherosclerotic heart disease of native coronary artery (a build-up of fats, cholesterol, and other substances in and on the artery walls causing obstruction of blood flow) without angina pectoris (chest pain). Current physician orders included the following: clopidogrel bisulfate (antiplatelet - used to inhibit blood clot formation) 75 mg daily (11/20/23), mirtazapine (antidepressant) 7.5 mg daily at bedtime (2/16/24), risperidone (antipsychotic) 0.5 mg daily in the morning (3/2/24), risperidone 1 mg daily at bedtime (3/1/24), and sertraline (antidepressant) 100 mg daily (1/24/24). A quarterly MDS assessment, dated 2/20/24, indicated the resident received insulin. The assessment did not indicate the resident received an antidepressant or an antiplatelet. The resident's medication administration record (MAR) for February 2024 indicated the resident received an antiplatelet medication (clopidogrel bisulfate) on 2/16/24, 2/17/24, 2/18/24, and 2/19/24. The resident received an antidepressant at bedtime (mirtazapine) on 2/16/24, 2/17/24, 2/18/24, 2/19/24, and 2/20/24 and an antidepressant (sertraline) in the morning on 2/16/24, 2/17/24, 2/18/24, and 2/19/24. A quarterly MDS assessment, dated 5/5/24, indicated the resident received insulin and did not receive an antipsychotic. The assessment did not indicate the resident received an antidepressant or an antiplatelet. The resident's MAR for May 2024 indicated the resident received an antiplatelet (clopidogrel bisulfate) on 5/2/24, 5/3/24, and 5/4/24. The resident received an antidepressant (mirtazapine) at bedtime on 5/3/24 and 5/4/24 and an antidepressant (sertraline) in the morning on 5/2/24, 5/3/24, and 5/4/24. She received an antipsychotic (risperidone) in the morning on 5/2/24, 5/3/24, and 5/4/24 and at bedtime on 5/3/24 and 5/4/24. During an interview, on 6/28/24 at 2:19 p.m., the MDS coordinator indicated she had reviewed the MAR prior to completing the MDS. She had seen where the resident had often refused medications and had thought the resident had refused the medications during the assessment windows. The resident had received an antidepressant, an antiplatelet, and an antipsychotic medication during the May assessment window. The resident did not receive an antipsychotic in the February assessment window, as it had not been ordered at that time. During an interview, on 7/1/24 at 3:58 p.m., the [NAME] President of Operations indicated the facility utilized the Resident Assessment Instrument (RAI) manual for the MDS policy. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The RAI manual, version 1.18.11, October 2023, indicated .High-Risk Drug Classes: Use and Indication . Coding Instructions .Code all high-risk drug class medications according to their pharmacological classification, not how they are being used .Antipsychotic: Check if an antipsychotic medication was taken by the resident any time during the 7-day look-back period .Antidepressant: Check if an antidepressant medication was taken by the resident any time during the 7-day look-back period .Antiplatelet: Check if there is an indication noted for all antiplatelet medications taken by the resident any time during the observation period

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 45122 Based on observation, record review, and interview, the facility failed to provide grooming assistance (Resident C and D) and provide scheduled showers (Resident D) for 2 of 4 residents reviewed for activities of daily living (ADLs). Findings include: 1. During an interview, on 6/25/24 at 11:43 a.m., Resident D's representative indicated the resident's fingernails were always dirty. During an observation, on 6/25/24 at 4:26 p.m., Resident D was lying in bed. Her fingernails had a brown substance under the tips. During an observation, on 6/26/24 at 9:44 a.m., the resident was lying in bed. A brown substance was under her fingernail tips. The resident indicated she wanted a sponge bath. Resident D's clinical record was reviewed on 6/25/24 at 4:12 p.m. Diagnoses included depression, delusional disorders, hallucinations, unspecified, vascular dementia, moderate, with agitation, and need for assistance with personal care. A quarterly Minimum Data Set (MDS) assessment, dated 5/5/24, indicated the resident was moderately cognitively impaired. No behaviors were identified. She required substantial/maximal assistance of staff for showering/bathing self, toileting hygiene, upper and lower body dressing, and personal hygiene. Rejection of care was not present during the assessment period. A care plan focus, initiated and revised on 11/22/23, indicated the resident had an ADL self-care/mobility performance deficit related to impaired balance. Interventions included the following: if resident resists with ADLs, reassure resident, leave and return in five to ten minutes later and try again and the resident's usual performance with showers/baths required assistance. A care plan focus, initiated and revised on 11/22/23, indicated the resident required assistance or was dependent for the following ADLs: oral/dental care, bed mobility, transfers, walking, locomotion, dressing, eating, toilet use, personal hygiene, and bathing. Interventions included assist with personal hygiene as needed including oral/dental care. A care plan focus, initiated 12/1/23 and revised on 2/1/24, indicated the resident was noncompliant/resistive with care interventions refusing medications. Interventions included the following: Encourage the resident to bathe for the health and safety of others, Encourage the resident to be compliant with care, Have staff that is most compatible provide care, Leave resident alone and re-approach as needed, and Reorient and cue resident as needed. Each of the interventions was initiated on 12/1/23. The documentation notes for bathing/showers indicated baths/showers were provided on 5/28/24, 6/1/24, 6/4/24, 6/7/24, 6/11/24, 6/18/24, and 6/21/24. No shower/bath was documented between 6/11/24 and 6/18/24. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The documentation notes for behaviors indicated the resident had no behaviors listed including rejection of care from 5/27/24 through 6/24/24. The progress notes lacked refusals of fingernail care or showers from 5/28/24 through 6/24/24. During an interview, on 6/27/24 at 11:13 a.m., CNA 4 indicated showers were usually given twice a week. When a resident refused a shower, a bed bath was attempted. The CNA was supposed to attempt to shower a resident three times. If the resident continued to refuse the shower, then the CNA notified the nurse. If a resident was diabetic, the CNA was not permitted to trim the resident's fingernails but was permitted to clean the resident's fingernails. Behaviors were documented in the electronic medical record. During an interview, on 6/27/24 at 3:49 p.m., CNA 18 indicated when a resident refused a shower three times the nurse was notified. A shower sheet was signed by the nurse and the resident. Nail care was completed with showers and when soiled. If the resident was diabetic, the CNA was not permitted to trim their nails. The nurse had to trim their nails. If the resident refused care, then the CNA reported it to the nurse. The nurse was supposed to chart the refusals. During an interview, on 6/28/24 at 10:05 a.m., CNA 4 indicated Resident D was diabetic, so the aides did not clip her fingernails but could clean her fingernails. She tried to do nailcare at least one day a week on everyone. During an interview, on 6/28/24 at 10:25 a.m., CNA 19 indicated Resident D wanted showers a lot. Sometimes, the resident's family performed fingernail care for the resident. The resident often scratched at herself. The resident would clean her own fingernails if she was given the orange stick by using the flat side of it. During an interview, on 6/28/24 at 10:40 a.m., LPN 8 indicated the aides could clean under the resident's fingernails. The aides needed to do a better job of charting. When there was one aide on the floor, it was difficult to complete the little things. During an interview, on 7/1/24 at 2:42 p.m., the DON indicated showers should be given twice a week. Fingernail care should be given with showers and as needed. Resident D sometimes refused care. The resident often ate chocolate donuts provided by the family, and she questioned if the brown substance under her nails was chocolate pudding. She would look to see if the resident had any documentation of refusals and would check the shower sheets. 2. During an observation, on 6/24/24 at 12:36 p.m., Resident C sat in his recliner in his room, he was unshaven. During an observation, on 6/25/24 at 8:44 a.m., the resident propelled himself in his wheelchair backwards down the hallway. He was unshaven. During an observation, on 6/25/24 at 10:43 a.m., the resident was in his room and was unshaven. His facial hair was slightly longer than the diameter of a pencil eraser. His fingernails extended over his fingertips. At the same time, the resident indicated he needed to have help with shaving, as he had very limited mobility on his dominant side from a stroke and could not do his own shaving. He had been trying to get someone to cut his nails for two days. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation, on 6/26/24 at 9:36 a.m., the resident's chin and cheeks were partially shaven with patches of remaining facial hair. During an observation, on 6/27/24 at 9:51 a.m., the resident was partially shaven with patches of remaining facial hair. His fingernails extended over his fingertips. At the same time, the resident indicated the aide that shaved him did one swipe down each side of his face. He was going to keep asking the staff about getting his fingernails trimmed until he got them cut today. He indicated his fingernails looked like claws. Resident C's clinical record was reviewed on 6/25/24 at 3:20 p.m. Diagnoses included hemiplegia and hemiparesis following cerebral infarction (stroke) affecting right dominant side, generalized anxiety disorder, major depressive disorder, recurrent severe without psychotic features, chronic pain syndrome, need for assistance with personal care, abnormal posture, and contracture, right wrist. A quarterly MDS assessment, dated 5/17/24, indicated the resident was cognitively intact. No behaviors were identified. His upper and lower extremities were impaired on one side. He required substantial/maximal assistance of staff for showering/bathing, upper and lower body dressing, and personal hygiene. Rejection of care was not present during the assessment period. A care plan focus, initiated and revised on 1/30/24, indicated the resident had an ADL self-care deficit and required assistance or was dependent for the following ADLs: oral/dental care, bed mobility, transfers, dressing, toilet use, personal hygiene, and bathing. Interventions included assist with personal hygiene as needed including oral/dental care initiated 1/30/24. A care plan focus, initiated and revised on 1/30/24, indicated the resident had an ADL self-care/mobility performance deficit that may fluctuate with activity throughout the day related to impaired balance. Interventions included the following: If the resident resists with ADLS, reassure resident, leave and return five to ten minutes later and try again, Monitor/document resident's abilities for ADLs and assist the resident as needed, Encourage the resident to do what they are capable of doing for self, and Provide the resident with opportunities for choice during care. All interventions were initiated on 1/30/24. The documentation notes for behaviors indicated the resident had no behaviors listed including rejection of care from 5/27/24 through 6/24/24. The progress notes lacked refusals of fingernail care or shaving from 5/28/24 through 6/24/24. During an interview, on 6/27/24 at 11:13 a.m., CNA 4 indicated shaving was typically done on shower days. If a resident would not allow a CNA to perform care, then sometimes a second aide would do the care as the resident allowed. Behaviors like yelling out or refusing care were documented in the electronic medical record. During an interview, on 6/27/24 at 3:49 p.m., CNA 18 indicated she shaved the resident with every shower and as needed. Men were to be shaved daily. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview, on 6/28/24 at 10:05 a.m., CNA 4 indicated she was uncertain if the resident had shaving cream or razors. The aides should have checked with him about shaving. Men were shaved twice a week. Nailcare and shaving were done on shower days. Whether nailcare or shaving were done often depended on who was working and how much help was available. During an interview, on 6/28/24 at 10:25 a.m., CNA 19 indicated the resident did most of his own care. He generally asked on Saturday for assistance. If he was not in the mood, he told the staff to go away. During an interview, on 6/28/24 at 10:40 a.m., LPN 8 indicated the resident had asked her today about fingernail care, which she observed he needed. He allowed the staff to shave him. She had never heard of him refusing care. During an interview, on 7/1/24 at 2:42 p.m., the DON indicated fingernail care should be given with showers twice a week and as needed. The resident sometimes refused to allow staff to shave him. She would look to see if the resident had any documentation of refusals. A current facility policy, revised 1/31/18 and provided by the Administrator on 7/1/24 at 4:34 p.m., titled Shower and Tub Bath, indicated the following: . a shower or tub bath or bed/sponge bath will be offered according to the resident's preference two times per week or according to the resident's preferred frequency and as needed or requested A current facility policy, revised 1/25/18 and provided by the Administrator on 7/1/24 at 4:34 p.m., titled Nail Care, indicated the following: .Observe condition of resident nails during each time of bathing. Note cleanliness, length, uneven edges, hypertrophied nails .Licensed Nurse is to trim diabetic resident's nails A current undated facility policy, provided by the Administrator on 7/1/24 at 4:34 p.m., titled Shaving Male & Female Residents, indicated .Male residents will be assessed for daily shaving need and assisted as his functional needs indicate 3.1-38(a)(3)(D) 3.1-38(a)(3)(E) 3.1-38(b)(2)

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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. 45122 Based on observation, interview and record review, the facility failed to implement interventions to prevent the development of a pressure injury for 1 of 3 residents reviewed for pressure injuries. (Resident 31) Finding includes: During an observation, on 6/24/24 at 12:15 p.m., Resident 31 was lying on his back in bed with heel boots on. During an observation, on 6/25/24 at 2:19 p.m., the resident was lying on his back in bed with heel boots on. During an observation, on 6/26/24 at 12:42 p.m., the resident was lying on his back in bed with heel boots on. Resident 31's clinical record was reviewed on 6/26/24 at 2:25 p.m. Diagnoses included methicillin susceptible staphylococcus aureus infection as the cause of diseases classified elsewhere, nontraumatic hematoma of soft tissue, other mechanical complication of surgically created arteriovenous fistula, dependence on renal dialysis, type 2 diabetes mellitus with diabetic neuropathy, peripheral vascular disease, diastolic (congestive) heart failure, and need for assistance with personal care. Current physician orders included the following: Wash wound to the right heel with wound cleanser, pat dry, apply hydrogel (gel composed usually of one or more polymers suspended in water) to the wound bed, cover with an abdominal pad, and wrap with a prewashed, fluff-dried 100% woven gauze with crinkle pattern every day shift for wound care (5/2/24) and Proheal Sugar Free Critical Care AWC (advanced wound care) 30 ml two times a day for wound healing (5/6/24). A quarterly Minimum Data Set (MDS) assessment, dated 9/14/23, indicated the resident was cognitively intact. The resident required substantial/maximal assistance of staff for toileting hygiene, upper body and lower body dressing, rolling left and right, moving from lying position to sitting and sitting to lying position, and for transfers. A quarterly MDS assessment, dated 4/16/24, indicated the resident was cognitively intact. No behaviors were exhibited. The resident required substantial/maximal assistance of staff for toileting hygiene, upper body and lower body dressing, rolling left and right, moving from lying position to sitting and sitting to lying position, and for transfers. (continued on next page)

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

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A care plan focus, initiated and revised on 6/20/23, indicated the resident had an ADL (activities of daily living) self-care performance deficit including bed mobility, eating, transfers, and toileting related to end stage renal disease requiring hemodialysis, falls, peripheral vascular disease, anemia, congestive heart failure, impaired mobility, cardiomyopathy, left lower extremity hematoma, and diabetes mellitus with neuropathy. Interventions included the following: Bed mobility: the resident requires extensive staff assistance to turn and reposition in bed with care and as necessary (6/20/23), Skin observation: the resident requires skin observation with are and as needed. Observe the redness, open areas, scratches, cuts, bruises, and report changes to the nurse (6/20/23), and Encourage the resident to participate to the fullest extent possible with each interaction (6/20/23). A care plan focus, initiated and revised on 6/20/23, indicated the resident had a potential for impairment to skin integrity. Interventions included avoid shearing: use lift sheet for repositioning (6/20/23), assess/record changes in skin status (6/20/23), avoid skin-to-skin contact (6/20/23), and use caution in transfers and bed mobility to prevent striking arms, legs, and hands against any sharp or hard surface. A care plan focus, initiated on 11/30/23 and revised on 12/12/23, indicated the resident had an unstageable (unable to visualize the wound bed due to dead tissue in order to determine stage) wound to the right heel related to the disease process and immobility. Interventions included the following: administer treatments as ordered and monitor for effectiveness (11/30/23), float heels (11/30/23), pressure relief boots when in bed (11/30/23), Proheal supplement twice a day (11/30/23), and turn and reposition every 2 hours (11/30/23). A care plan focus, initiated and revised on 3/6/24, indicated the resident was non-compliant/resistive to care with care interventions including medication refusal, Diet Restrictions (diabetic diet), showers/baths. Interventions included educated the resident/family/caregiver of possible negative outcomes related to noncompliance (3/6/24), encourage resident to bathe for the health and safety of others (3/6/24), encourage the resident to be compliant with care (3/6/24), have staff that is most compatible provide care (3/6/24), leave resident alone and re-approach later as needed (3/6/24) and reorient and cue resident as needed (3/6/24). The care plan lacked individualized interventions specific to avoiding shearing or skin to skin contact for Resident 31. The nurses' notes lacked documentation of refusal of care from 9/30/23 through 11/30/23. A weekly skin observation note, dated 11/30/23 at 3:40 p.m., indicated the resident had a deep tissue injury (purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear) measuring 2 centimeters (cm) length (L) by 4 cm width (W) to the right heel. A nurses note, dated on 12/28/23 at 2:56 a.m., indicated the resident was transferred to the hospital due to a burst artery in his left leg. A nurses note, dated 1/19/24 at 9:32 a.m., indicated the resident was readmitted to the facility with an unstageable pressure injury to his right heel. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A wound summary for Resident 31, provided by the DON on 6/26/24 at 3:30 p.m., indicated the resident had an unstageable pressure injury to the right heel. On 1/22/24, the pressure injury measured 3.0 cm L by 4.0 cm W. The wound bed was 10% pink or red non-granulating (surface smooth and red) tissue, 30% slough (yellow/white dead tissue), and 60% necrotic (nonviable tissue), hard, firmly adherent tissue. On 6/18/24, the pressure injury measured 1.4 cm L by 2.0 cm W. The wound bed was 100 % pink or red non-granulating tissue. During a wound observation, on 6/27/24 at 3:28 p.m., accompanied by LPN 8, Resident 31's pressure injury to the right heel had a beefy red wound bed and approximately the size of a quarter. During an interview, on 6/28/24 at 10:05 a.m., CNA 4 indicated the resident did not want to get out of bed. He got out of bed only to go to dialysis and for showers. During an interview, on 6/28/24 at 10:25 a.m., CNA 19 indicated the resident did not want to get up at all. He got angry when he was asked if he would like to get up. He wore heel protectors. During an interview, on 7/1/24 at 2:42 p.m., the DON indicated the resident liked to stay in bed. She was unable to provide documentation of resident refusals of care prior to the development of the pressure injury to his right heel. Resident 31's plan of care lacked individualized interventions related to the resident's condition and preference to stay in bed/immobility. A current facility policy, revised on 1/15/18, titled Pressure Ulcer Prevention, provided by the Administrator on 7/1/24 at 4:34 p.m., indicated the following: .Turn dependent residents approximately every two hours or as needed .whenever possible, encourage resident to change position at regular interval as able to promote circulation as indicated 3.1-40(a)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. 50721 Based on observation, interview, and record review, the facility failed to address the dietary needs for a dialysis resident related to impaired nutrition for 1 of 1 resident reviewed for dialysis. (Resident 28) Finding includes: During an observation, on 6/25/24 at 2:32 p.m., Resident 28 was sitting in a wheelchair in his room. His lunch tray was sitting on his table in front of him with meatloaf, mixed vegetables, a dessert, coffee and an empty cup with remnants of a brown liquid. He ate less than 25% of his meatloaf and nothing else. He indicated the food lacked something but could not verbalize what. There were no condiments on his tray. He stated, It's just too hard with these teeth. He was wearing dentures. During an observation, on 6/26/24 at 9:19 a.m., the resident was eating his breakfast while watching TV. His breakfast plate was empty and he indicated his food was actually warm today. He did not eat any of the oatmeal. He drank his coffee and there was a milk carton on his tray. He indicated that he did not get lunch prior to or during dialysis that he attended every Monday, Wednesday, and Friday. The resident indicated he got food upon returning to facility at times but it was usually not warm. Several salt shakers, pepper, and another seasoning were on the table. During an observation, on 6/26/24 at 1:05 p.m., facility staff delivered trays from the meal cart while Resident 28 was in dialysis. Certified Nurse Aide (CNA) 4 indicated that the resident would be offered food when he returned from dialysis because he was normally gone until 3:30 or 4:00 p.m. on dialysis days. On the same date at 4:32 p.m., the resident was escorted back from dialysis to his room by the ambulance staff. During an interview on the same date at 5:12 p.m., the resident indicated no one had checked on him since he had returned from dialysis and he was hungry. The resident activated his call light at that time and CNA 5 responded. The resident indicated that he was hungry and she responded dinner would be delivered soon. The resident stated, That may be two hours. CNA 5 indicated it should not take that long, turned off the call light and left the room. She did not offer him anything to eat until dinner arrived. During an interview on 6/27/24 at 10:36 a.m., CNA 6 indicated she had worked at the facility for about 90 days. She had never noticed the resident's dentures dropping down in his mouth and had not offered any denture adhesive during his care. During an interview on 6/27/24 11:10 a.m., the DON indicated that an early lunch tray was sometimes offered prior to the resident leaving for dialysis or upon his return. The DON indicated the dialysis center did not provide food or drinks to residents. During an observation on 6/28/24 at 9:18 a.m., the resident was eating breakfast, started talking, and his upper dentures dropped down into his mouth. He grabbed his dentures, cursed, and threw his upper dentures onto his recliner. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/28/24 at 9:04 a.m., LPN 7 indicated she worked on an as needed basis (PRN). She indicated that at times, when ambulance staff transported the resident back to his room from dialysis, they did not always notify facility staff that the resident had returned. She indicated the facility staff offered food when the resident returned from dialysis. When the resident returned from dialysis, snacks should be offered even if it was close to dinner time. During an observation on 7/01/24 at 9:09 a.m., the resident was sitting in his wheelchair in his room. His breakfast tray had not been delivered yet. He was scheduled to go to dialysis at 11:30 a.m. On the same date at 10:49 a.m., the resident was sitting at the front desk. The business office manager (BOM) gave the resident cash. During an interview at the time of the observation, the resident indicated he was unsure if he had eaten breakfast. He was unable to recall whether he was offered a snack prior to being brought to the front of facility and was unable to state whether he was hungry or not. He indicated the facility gave him five dollars to be used to buy food in case the driver stopped to pick up food before or after dialysis. The resident's clinical record was reviewed on 6/25/24 at 2:39 p.m. Diagnoses included but were not limited to: chronic kidney disease stage 4 (severe), dependence on renal dialysis, unspecified protein-calorie malnutrition, and cognitive communication deficit. Current physician orders included regular diet with thin consistency and no tomatoes, bananas, orange juice or potatoes (5/20/24), Nepro supplement one time daily for nutrition support, lunch at 1030 prior to leaving for dialysis at 1130 every Monday, Wednesday, Friday (5/22/24), and Nephro-Vite 1 tablet daily (5/11/24). The 5/13/24 annual Minimum Data Set (MDS) assessment indicated the resident was severely cognitively impaired. He weighed 224 pounds with no or unknown weight loss or gain. A care plan initiated on 9/26/21 indicated the following: I have a nutritional problem or potential nutritional problem related to risk for weight fluctuations .which may affect weight/ appetite. Interventions included: I will maintain current body weight +/- 3% through next review(10/2/21), encourage PO (by mouth) intake of meals/snacks/fluids (11/30/21), monitor PO intake and record every meal (11/30/21), provide diet as ordered (9/26/2021), weigh at same time of day and record as ordered (9/26/21). Additional focus indicated the following: I am at risk for complications related to protein calorie malnutrition. Interventions included: I will eat 75% or more of most meals (5/20/24), offer substitutes if 50% or less is consumed (9/27/21), provide diet as ordered and fluids at consistency ordered (9/27/21), and provide/observe intake of diet/fluids/ snacks (9/27/21). The resident's weight history, in pounds, was as follows: 202.4 on 12/22/23 211.3 on 3/1/24 223.6 on 5/10/24 192.2 on 6/14/24 (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The nutritional intake form, dated from 5/30/24 through 6/27/24, demonstrated documentation for one meal consumed on 6/19/24 and 6/24/24. For all other included dates, when resident was at dialysis, meal percentages were documented for three meals daily. The Long Term Care Facility Outpatient Dialysis Services Coordination Agreement, provided during the entrance conference, indicated the long term care facility shall ensure that ESRD residents are prepared to spend an extended length of time at the ESRD dialysis unit and have received proper nourishment .before coming to the ESRD dialysis unit 3.1-46(a)(1)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. 45122 Based on observation, interview, and record review, the facility failed to provide pain medications as ordered for 2 of 3 residents reviewed for pain management. (Resident 22 and Resident 108) Findings include: 1. During an observation, on 6/25/24 at 8:44 a.m., Resident C groaned and grimaced as he propelled himself in his wheelchair down the hall. At the same time, he indicated he had requested to see the physician about his hand and leg. He had been on painkillers for quite a while. He thought his body had gotten used to them and wanted to see if the physician could order him something different Resident C's clinical record was reviewed on 6/25/24 at 3:20 p.m. Diagnoses included hemiplegia and hemiparesis following cerebral infarction (stroke) affecting right dominant side, generalized anxiety disorder, major depressive disorder, recurrent severe without psychotic features, chronic pain syndrome, abnormal posture, contracture, right wrist, varicose veins of right lower extremity with pain, unilateral primary osteoarthritis, right hip, arthropathy, unspecified, opioid dependence, uncomplicated, and other psychoactive substance dependence, uncomplicated. Physician orders included the following: escitalopram (antidepressant) 10 mg daily started 1/30/24, mirtazapine (antidepressant)15 mg daily started 1/30/24, olanzapine (antipsychotic) 7.5 mg daily started 1/30/24, buspirone (antianxiety) 10 mg three times a day started 1/30/24, oxycodone (opioid for pain management) 20 mg three times a day started 1/30/24, fentanyl (opioid for pain management) transdermal patch 100 mcg/hr apply 1 patch transdermally every 72 hours for pain started 4/19/24 and discontinued 6/6/24, tizanidine (muscle relaxant) 2 mg daily every 24 hours as needed for muscle spasms started 6/6/24, and pain assessment every shift started 1/29/24. A quarterly Minimum Data Set (MDS) assessment indicated the resident was cognitively intact. He complained of frequent pain which interfered frequently with therapy activities and day to day activities. The resident rated the pain as 7 on a 0 - 10 pain scale with 0 being no pain and 10 being the worst pain ever felt. A care plan focus, initiated and revised on 1/30/24, indicated the resident was on pain medication therapy. Interventions included administer analgesic medications as ordered by the physician and monitor/document side effects and effectiveness every shift. The interventions were initiated on 1/30/24. A care plan focus, initiated and revised on 1/30/24, indicated the resident had pain. Interventions included the following: Anticipate the resident's need for pain relief and respond immediately to any complaint of pain. Notify the physician if interventions are unsuccessful or if current complaint is a significant change from residents past experience of pain. The interventions were initiated on 1/30/24. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The May 2024 medication administration record (MAR) indicated the fentanyl patch was not applied on 5/28/24 or on 5/31/24 as ordered due to unavailability of the medication. The pain assessment indicated the resident rated his pain as 10 on the 0-10 pain scale on 5/28/24 during the night and 8 on 5/31/24 during the night. A progress note, dated 5/29/24 at 1:59 p.m., indicated the resident's fentanyl patch that was due to be removed on night shift at 5/28/24 was removed at that time. The facility was waiting for a supply of the fentanyl patches to arrive at the facility. The nurse practitioner (NP) was notified, and no new orders were received. The June 2024 MAR indicated the fentanyl patch was not applied as ordered on 6/3/24 due to the unavailability of the medication. The pain assessment indicated the resident rated his pain as 8 on the 0-10 pain scale on 6/1/24 during the night and 8 on 6/6/24 during the night. The pain assessment completed prior to the administration of oxycodone indicated the resident rated his pain as 6 on 6/1/24 at 8:00 a.m., 8 on 6/1/24 at 8:00 p.m., 8 on 6/2/24 at 8:00 p.m., 8 on 6/3/24 at 8:00 p.m., and 8 on 6/6/24 at 8:00 p.m. An NP progress note, dated 6/3/24 at 11:21 a.m., indicated the NP assessed the resident. The fentanyl patch order was listed as active. The assessment lacked mention of the resident's fentanyl patch being unavailable. A progress note, dated 6/3/24 at 11:54 p.m., indicated the fentanyl patch was not available. The pharmacy was aware. The facility was awaiting delivery of the patch from pharmacy. A progress note, dated 6/6/24 at 12:11 p.m., indicated the resident had been seen by the NP. The fentanyl patch was discontinued and tizanidine was ordered as needed. The progress notes lacked notification of the medical provider of the unavailability of the fentanyl patch from 5/30/24 through 6/5/24. During an interview, on 6/28/24 at 10:40 a.m., LPN 8, indicated if a resident did not have a medication, she would check the overflow medication cart, the medication room, and the other medication cart to ensure it was not put in the wrong cart. Then, she would notify the physician of the medication's unavailability and await further instruction. She indicated the resident's patch had been reordered and did not know much more about it. In the event a resident's patch was unavailable, she would notify the physician about not having the patch, see if the patch could be put on hold, and check if the resident could be given something else until the patch arrived. During an interview, on 6/28/24 at 11:22 a.m., LPN 7, indicated if a medication was unavailable, she would check the Emergency Drug Kit (EDK). If the medication was a narcotic, she would have to call the pharmacy and get a code to be able to pull it out of the EDK. She thought the EDK contained fentanyl patches. She would also call the pharmacy to have the patch sent immediately and call the DON who would call the physician/NP who could give a one time order for the missing medication. If the fentanyl patch dosage was higher than what was available in the EDK, she would ask the physician/NP if a lower dosage patch or two lower dosage patches would be appropriate. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview, on 6/28/24 at 5:06 p.m., the DON indicated she had tried to get a preauthorization from the physician for the patch. The insurance company would not pay for the fentanyl patches. She had contacted the physician several times about the resident not receiving the patch and had received no new orders, but had not documented the notifications. During the time the resident had not received his patch, she had seen and talked to the resident in the hall. He did not appear to be in any distress. She did not document her encounters with the resident. The NP had prescribed the resident tizanidine on 6/6/24 (nine days after the fentanyl patch was due to be applied, but was unavailable). The National Institute of Health's National Library of Medicine website, https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=2a2238e9-4b5d-c56d-8663-dd354ff9ae0c#section-2.9, accessed on 7/2/24 at 4:01 p.m., indicated the following: .2.9 Safe Reduction or Discontinuation of Fentanyl Transdermal System. Do not abruptly discontinue fentanyl transdermal system in patients who may be physically dependent on opioids. Rapid discontinuation of opioid analgesics in patients who are physically dependent on opioids has resulted in serious withdrawal symptoms, uncontrolled pain, and suicide 48384 2. Resident 108's clinical record was completed on 6/26/24 at 9:36 a.m. Diagnoses included Chronic Obstructive Pulmonary Disease (COPD), abnormalities of gait and mobility, unsteadiness on feet, and a need for assistance with personal care. An admission MDS assessment, dated 6/22/24, indicated the resident was cognitively intact. A physician's order, dated 6/20/24 at 6:00 p.m., indicated the resident should be assessed for pain every shift. A physician's order, dated 6/19/24 at 5:00 p.m., included Hydrocodone-Acetaminophen (a narcotic pain reliever) 5-325 mg, 1 tablet by mouth, every 4 hours, as needed, for moderate pain. A current care plan, dated 6/20/24, indicated to give medications as ordered by physician and to monitor and document side effects and effectiveness of medications. A review of routine shift pain assessments indicated a zero (0) pain rating, on a scale from 0 to 10, with 0 being no pain and 10 being the worst pain imaginable, was documented by nursing on 6/20/24, 6/21/24, 6/22/24, 6/23/24, 6/25/24, and 6/26/24. On 6/20/2024 at 9:30 a.m., the resident had rated his pain at 4/10 and was given a hydrocodone-acetaminophen 5-325 mg at that time. On 6/20/2024 at 3:30 p.m., the resident rated his pain at 7/10 and was given a hydrocodone-acetaminophen 5-325 mg at that time. On 6/20/2024 at 7:39 p.m., the resident rated his pain at 6/10 and was given a hydrocodone-acetaminophen 5-325 mg at that time. On 6/21/2024 08:35 a.m., the resident rated his pain at 6/10 and was given a hydrocodone-acetaminophen 5-325 mg at that time. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/21/2024 7:01 p.m., the resident rated his pain at 7/10 and was given a hydrocodone-acetaminophen 5-325 mg at that time. On 6/22/2024 9:22 a.m., the resident rated his pain at 8/10 and was given a hydrocodone-acetaminophen 5-325 mg at that time. On 6/22/2024 at 2:48 p.m., the resident rated his pain at 9/10 and was given a hydrocodone-acetaminophen 5-325 mg at that time. On 6/22/2024 9:05 p.m., the resident rated his pain at 8/10 and was given a hydrocodone-acetaminophen 5-325 mg at that time. During an interview with Resident 108 on 6/26/24, at 1:43 p.m., the resident indicated he had not received his pain medication for the last 3 to 4 days. Nursing told him that his medication was not available. No other medications were offered to help relieve his pain. On the same date, at 3:08 p.m., the resident indicated he was not being assessed for pain every shift. The only time pain levels were addressed was when he would ask for a pain pill. He would tell the staff his pain level at that time. His last pain pill was given on 6/22/24 at 9:05 p.m. At the time of the interview, the resident indicated his pain had not been assessed that day. On 6/26/24 at 3:00 p.m., two narcotic logs for the D hallway were reviewed . Neither log contained any information or narcotic medication for Resident 108. During an interview, on 6/26/24 at 3:14 p.m., LPN 8 indicated the resident had admitted to the facility with five (5) hydrocodone-acetaminophen 5-325 mg tablets. Since the depletion of the narcotic pain medication, the facility had been waiting on a prescription from the prescriber. She had sent a text message on 6/23/24 to the Director of Nursing (DON), asking her to contact the provider for a new prescription because the resident had only two tablets remaining. In regards to the inconsistency of the pain assessments in the electronic health record, LPN 8 was not aware of the discrepancies and could not give an explanation as to why the assessments would have conflicting information. Review of the medication administration record indicated on 6/27/24, at 10:52 p.m., the resident rated his pain at an 8/10 and received hydrocodone-acetaminophen 5-325 mg. The last administration was on 6/22/24 at 9:05 p.m. During an interview with LPN 8, on 6/28/24 at 3:25 p.m., she indicated the resident's hydrocodone-acetaminophen 5-325 mg was not delivered until 6/26/24. During an interview on 6/28/24 at 4:57 p.m., the ADON indicated a floor nurse had contacted her about Resident 108's pain medication being unavailable. She had previously educated the staff about their responsibility to contact the provider when an order was needed. There was also a phone number on the medication storage room door, which staff could use to contact the pharmacy when a medication ran out. Staff could get an authorization code from the pharmacy to pull the medication from the emergency drug kit (EDK). The DON contacted the provider on 6/26/24 and received an order for the medication. The clinical record lacked indication of pain assessments between 6/23/24 through 6/25/24. (continued on next page)

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

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A current facility policy titled Pain Management Program, was provided by the Administrator on 7/1/24 at 4:34 p.m. The policy indicated the following: .Purpose: To establish a program which can effectively manage pain in order to remove adverse physiologic and physiological effects of unrelieved pain and to develop an optimal pain management plan to enhance healing and promote physiological and psychological wellness . Standards: 1) Pain assessment protocol will be initiated under any of the following situations - a) Any indication of pain based on the pain assessment performed for each resident at the time of admission and with any condition change and/or incident associated with the potential of pain .c) Resident receives routine pain medication and/or pain is not controlled. 2) As soon as possible identify the best rating scale for the resident and use the same rating scale to determine the level of pain .10) Documentation of assessments and the resident's response to the pain management plan will be made with each assessment. 11) The resident's physician will be notified of the resident's complaints of pain which are not relieved by comfort measures, including pain medications. 12) Pain control will be assessed during routine medication passes A current facility policy, revised 1/31/18 and provided by the Administrator at 4:34 p.m., titled Physician's Orders - Entering and Processing, indicated the following: .Fax or call the orders to the appropriate pharmacy as needed .If a medication is needed immediately, it will be removed from the Emergency Drug Kit (EDK) 3.1-37(a)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 48384 Based on observation, interview, and record review, the facility failed to follow pharmacy recommendations for 1 of 5 residents reviewed for unnecessary medications. (Resident 1) Findings include: Resident 1's clinical record was reviewed on 6/26/24 at 2:39 p.m Diagnoses included schizophrenia, major depressive disorder, unspecified intellectual abilities, and anxiety disorder. A quarterly Minimum Data Set evaluation, dated 5/20/24, indicated the resident was cognitively intact and required substantial to maximal assistance from staff for activities of daily living. A gradual dose reduction recommendation from the pharmacist, dated 11/22/23, indicated the resident was receiving the antipsychotic medication Risperdal (antipsychotic) 2 mg by mouth twice a day. Residents taking Risperdal required an AIMS (abnormal involuntary movement scale) assessment to be performed every 6 months. The last assessment, noted by the pharmacist, was performed on 5/22/23. The resident was due for an AIMS assessment at the time of the recommendation. On 12/18/23, a second request from the pharmacist indicated the resident was receiving Risperdal 2 mg by mouth twice a day and needed an AIMS assessment. The last AIMS assessment was 5/22/23. A care plan, with a revision date of 5/19/23, indicated the resident was receiving psychotropic medications. The goal of the plan was the resident would remain free of psychotropic drug related complications, including movement disorder .or cognitive/behavioral impairment through the review date. The clinical record lacked indication of a completed AIMS assessment after 5/22/23. During an interview with the Director of Nursing (DON), she indicated she was aware of the two pharmacist requests for an AIMS assessment to be completed. She knew the last assessment was completed on 5/22/23. She was unable to provide a reason for the missed assessments. 3.1-48(3)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. 50721 Based on observation, interview, and record review, the facility failed to provide prompt dental services for ill-fitting dentures to 1 of 2 residents reviewed for dental services (Resident 28). Finding includes: The resident's record review was completed on 6/25/24 at 2:39 p.m. Medical diagnoses included, but were not limited to: unspecified protein-calorie malnutrition; anemia in Chronic Kidney Disease (CKD); and unspecified dementia with unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety. Current physician orders included regular diet,thin consistency with no tomatoes, bananas, orange juice or potatoes (5/20/2024). The annual Minimum Data Set (MDS) assessment completed on 5/13/24 indicated the resident did not have broken or loosely fitting full or partial dentures (chipped, cracked, uncleanable, or loose). A current care plan, initiated on 9/12/21, included: I exhibit dental/mouth problems: I have no natural teeth (9/12/21), I will not develop oral/dental complications (5/20/24), report changes in oral status to MD (9/26/21), report to nurse changes in oral status .dentures (broken, loose .)(9/27/21). A social services note, dated 11/17/23 at 3:20 p.m., indicated the resident was referred to the attending dentist per the request of the resident's daughter. A social services note, dated 1/26/2024 at 3:11 p.m., indicated the writer scheduled the resident a dental appointment for 2/19/24 at 9:20 a.m. and staff was made aware. A social services note, dated 3/28/2024 at 3:11 p.m., indicated the writer contacted the resident's daughter and notified her that the resident would be seen for an adjustment for his dentures on April 5, 2024. A nurse's note, dated 5/29/2024 at 11:03 a.m., indicated a Certified Nursing Assistant (CNA) attempted to put the resident's dentures in and he refused, stating they did not fit and had not fit for over three months. A nurse's note, dated 5/29/2024 at 11:10 a.m., indicated the resident was at the front of the facility talking with staff and other residents about throwing his dentures in the trash. A nurse spoke with resident and reminded him that he had refused to put the dentures in his mouth because they had not fit him for over three months. A social services note, dated 5/29/2024 at 11:14 a.m., indicated the writer spoke with the resident's daughter yesterday and informed her that the resident was scheduled to see the dentist and the resident was at dialysis when the dentist visited. The daughter stated that she wanted the resident seen by another dentist instead. (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An appointment departure note, dated 6/11/2024 at 12:00 p.m., indicated the resident LOA (leave of absence) to a dentist appointment. During an observation, on 6/25/24 at 2:32 p.m., the resident indicated it was too hard to eat with these teeth. He had upper and lower dentures in his mouth. During an interview, on 6/28/24 at 9:04 a.m., LPN 7 indicated it could take a long time for dentures to be fixed or replaced as dental services only came to facility about once a month. During an observation, on 6/28/24 at 9:18 a.m., the resident started talking and his upper dentures dropped down into his mouth. He grabbed his upper denture, cursed and threw the denture on to the recliner. During an interview, on 7/1/24 at 11:01 a.m., the MDS Coordinator indicated that there was an Interdisciplinary Team (IDT) meeting every morning and she was not aware of any issues with the resident's dentures not fitting because it had not been mentioned in the meetings. During a telephone interview, on 7/1/24 at 2:04 p.m., the resident's representative stated Resident 28's dentures had been ill-fitting since October 2023 and the facility had been aware since that time. The resident had not been seen by a dentist until 6/11/2024 and had impressions made for new dentures and was scheduled the following day for an appointment. The representative was unaware of any adjustments that had previously been made to the resident's dentures. A current facility policy, dated 11/28/17, provided by the Administrator on 6/27/24 at 11:25 a.m., titled Dental Services and Loss or Damage of Dentures indicated The facility will, if necessary or requested by the resident .arranging .promptly refer residents with lost or damaged dentures for dental services .Prompt referral means, within reason, as soon as the dentures .damaged .this referral should occur within 3 business days 3.1-24(a)(3)

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. 45122 Based on interview and record review, the facility failed to ensure a qualified dietary manager supervised the kitchen staff and operations. This deficiency had the potential to affect 54 of 55 residents who received meals from the facility kitchen. Finding includes: During an interview, on 6/24/24 at 10:13 a.m., the Head [NAME] indicated the kitchen had been without a manager for six to seven months. During an interview, on 6/24/24 at 4:14 p.m., the Administrator indicated the facility did not currently have a dietary manager. She was filling in as the dietary manager. The employee records, provided by the Administrator on 6/25/24 at 9:50 a.m., did not include a dietary manager. During an interview, on 6/27/24 at 9:24 a.m., the Head [NAME] indicated she was not certified as a dietary manager, but she and the Administrator had been discussing getting her into a certification class. She indicated the dietician came in about three times a month. During an interview, on 6/28/24 at 11:55 a.m., the Administrator indicated a new dietary manager had started on 6/24/24. The prior dietary manager had been terminated in the past couple of weeks. She was unable to provide a dietary manager certification for the prior dietary manager. During an interview, on 6/28/24 at 3:56 p.m., the Administrator indicated the new dietary manager was being trained this week. She indicated the facility had not had a dietary manager for several months. The newly hired dietary manager's employee record, provided by the Administrator on 6/28/24 at 4:02 p.m., was reviewed. The newly hired dietary manager had a physical on 6/25/24 and had signed a [NAME] job description. She had a ServSafe food production manager certification that would expire on 8/18/2025. During an interview, on 7/1/24 at 4:29 p.m., the Administrator indicated the dietician came in once a month. One resident received nutrition only through a feeding tube, the remaining 54 residents received their meals and/or snacks from the kitchen. A Time Card Report, provided by the Administrator on 7/1/24 at 4:33 p.m., indicated the dietician had been in the facility on 6/19/24 for 8 hours. (continued on next page)

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Indiana Department of Health Long-term Care Newsletter, dated 10/26/23, retrieved from https://www.in.gov/health/ltc/files/2023-23.pdf on 7/3/24 at 12:02 p.m., indicated the following .Dietary Manager Qualifications: Effective Oct. 1, the Centers for Medicare and Medicaid Services requires the following qualifications for the director of food and nutrition services under F801 of the State Operations Manual, S483.60(a)(2). 'If a qualified dietitian or other clinically qualified nutrition professional is not employed fulltime, the facility must designate a person to serve as the director of food and nutrition services. (i) The director of food and nutrition services must at a minimum meet one of the following qualifications- (A) A certified dietary manager; or (B) A certified food service manager; or (C) Has similar national certification for food service management and safety from a national certifying body; or (D) Has an associate's or higher degree in food service management or in hospitality, if the course study includes food service or restaurant management, from an accredited institution of higher learning; or (E) Has 2 or more years of experience in the position of director of food and nutrition services in a nursing facility setting and has completed a course of study in food safety and management, by no later than October 1, 2023, that includes topics integral to managing dietary operations including, but not limited to, foodborne illness, sanitation procedures, and food purchasing/receiving Certification from ServSafe, or similar national certification for food service management and safety from a national certifying body, meets the requirement for option C, S483.60(a)(2(i)(C). Successful completion of the ServSafe food manager program (or other nationally recognized course of study in food safety and management) by Oct. 1 AND two or more years of experience as a director of food and nutrition services in a nursing facility setting, meets the regulatory requirement of the option E, described in S483.60(a)(2(i)(E) ' 3.1-20(c)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 45122 Based on observation, interview, and record review, the facility failed to implement infection prevention strategies related to enhanced barrier precautions (EBP) for 2 of 4 residents reviewed for transmission-based precautions. (Resident 44 and Resident 53) Findings include: 1. During an observation, on 6/24/24 at 12:15 p.m., Resident 53 was lying in his bed. The resident's door and room had no posted signage. During an observation, on 6/25/24 at 2:19 p.m., the resident was lying on his back in bed with his eyes closed. The resident's door had no posted signage. Resident 53's clinical record was reviewed on 6/26/24 at 2:25 p.m. Diagnoses included methicillin susceptible staphylococcus aureus infection as the cause of diseases classified elsewhere, nontraumatic hematoma of soft tissue, other mechanical complication of surgically created arteriovenous fistula, and dependence on renal dialysis. The physician orders lacked an order for enhanced barrier precautions. A progress note, dated 1/19/24 at 1:24 p.m., indicated the resident readmitted to the facility with a wound to the left lower leg with an attached wound vacuum. A wound summary, provided by the DON on 6/26/24 at 3:30 p.m., indicated the resident had a surgical wound to the left outer calf. On 1/22/24, the surgical wound measured 14 cm long by 13 cm wide. The wound bed was 60 % bright beefy red tissue, 15% slough, and 25% necrotic tissue. On, 6/18/24, the surgical wound measured 4.0 cm wide by 2.4 cm wide. The wound bed was 100 % bright pink or red tissue. A wound summary, provided by the DON on 6/26/24 at 3:30 p.m., indicated the resident had an unstageable pressure injury to the right heel. On 1/22/24, the pressure injury measured 3.0 cm long by 4.0 cm wide. The wound bed was 10% pink or red non-granulating (surface smooth and red) tissue, 30% slough (yellow/white dead tissue), and 60% necrotic (nonviable tissue), hard, firmly adherent tissue. On 6/18/24, the pressure injury measured 1.4 cm long by 2.0 cm wide. The wound bed was 100 % pink or red non-granulating tissue. During an interview, on 6/26/24 at 10:09 a.m., CNA 23 indicated if a person was on EBP it would be on the door and the PPE would be inside the room. If the PPE chest was outside the room, then it was some other type of isolation precautions. She indicated there were two residents on the D Hall that were on precautions. She did not include Resident 53. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a wound observation, on 6/27/24 at 3:28 p.m., LPN 8 washed her hands, applied gloves and proceeded to perform pressure injury wound care and surgical wound care. The pressure injury wound bed was beefy red, and quarter sized on the right heel. The surgical wound bed was beefy red on the left lower leg. LPN 8 did not apply a gown prior to the dressing change. The door and room lacked signage and PPE for EBP. During an interview, on 6/28/24 at 10:40 a.m., LPN 8 indicated Resident 53 was not on EBP because one of his wounds was surgical. During an interview, on 6/28/24 at 2:35 p.m., the DON indicated Resident 53 should have been placed on EBP. During an interview, on 6/28/24 at 5:06 p.m., the DON indicated she had spoken to her corporate infection preventionist about the resident and EBP. The resident's wounds were considered chronic and had existed greater than 28 days. He required EBP. 50721 2. Resident 44's clinical record was reviewed on 6/26/24 at 9:28 a.m. Diagnoses included: other abnormalities of gait and mobility and Type 2 diabetes mellitus without complications. During an observation on 6/24/24 at 10:20 a.m., Resident 44's door was open and an Enhanced Barrier Precautions (EBP) sign was located on the door. A personal protective equipment (PPE) cart was located outside of her room. A wound summary, provided by the DON, on 6/26/24 at 3:35 p.m., indicated the resident had an active pressure wound to her coccyx, present on admission. On 6/18/24 at 11:45 a.m., the assessment indicated the pressure ulcer measured 0.4 cm wide, 0.4 cm long and 0.4 cm deep, 100% bright pink or red with no undermining, no tunneling and no exudate (drainage). On a prior assessment, dated 4/9/24 at 2:49 p.m., the pressure ulcer measured 1.0 cm wide, 0.5 cm long, and 0.5 cm deep. During a wound observation on 6/27/24 at 3:34 p.m. the ADON performed wound care for Resident 44. During an interview at the same time, the ADON indicated that she did not wear a gown and should have worn a gown during the dressing change as the resident has an EBP sign on the door and a gown should be worn during pressure ulcer dressing changes. A current facility policy, revised 5/7/24, provided by the Administrator on 7/1/24 at 4:34 p.m., titled Enhanced Barrier Precautions, indicated the following: .EBP are indicated for residents with any of the following: . Chronic Wounds .Examples of chronic wounds include, but are not limited to: Pressure ulcers, Diabetic foot ulcers, Unhealed surgical wounds, Venous stasis ulcers .For residents for whom EBP are indicated, EBP is employed when performing the following high-contact resident activities .Dressing, Bathing/showering, Transferring, Providing hygiene, Changing linens, Changing briefs or assisting with toileting .Wound care: any chronic skin opening requiring a dressing 3.1-18(b)(2)