

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 04/22/2026
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)
<p>F 0882</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home.</p> <p>Based on interview and record review, the facility failed to ensure the designated Infection Preventionist (IP) worked the required hours to manage the Infection Prevention and Control Program (IPCP), including infection surveillance, staff training, and antibiotic stewardship monitoring to mitigate the risk of the spread of infection. This deficient practice had the potential to affect 62 residents living in the facility. Findings include: During an interview with the Director of Nursing (DON) on 4/16/26 at 3:55 p.m., she indicated she had served as the facility's Infection Preventionist (IP) for the last five years. During an interview with the DON on 4/20/26 at 9:57 a.m., she indicated she was the person in charge of infection prevention. The ADON was her backup, when needed. The ADON was also certified in infection prevention. The ADON worked 30 hours a week. The DON worked 40 hours a week as the DON. She indicated she focused on IP during her regular workday(s) as needed. If she needed to stay over an hour or two here and there, she would. During an interview with the Administrator on 4/20/26 at 10:01 a.m., she indicated the DON was the primary IP. The DON worked approximately 60 hours per week. The DON position was a salaried position, so the Administrator was unable to provide timecards or documentation of the actual hours worked per week by the DON. The Administrator felt the DON put in 40 hours a week, on top of her hours working as IP. A current facility policy titled Infection Preventionist - Job Description, provided by the Administrator on 4/21/26 at 9:37 a.m., indicated the following: .The role of the Infection Preventionist is to oversee the infection prevention and control program for the surveillance, investigation, prevention, and control of healthcare-associated infections and other infectious diseases. Essential Duties and Responsibilities May Include But Not Limited To The Following: 1) Infection Prevention & Control - tracking and trending of infections 2) Line Listing reports 3) Vaccination Tracking 4) Antibiotic Stewardship program oversight 5) Infection Control rounding and observations 6) Performance Improvement 7) Occupational Health 8) Occupational Safety and Health Administration's (OSHA) Respiratory Protection Program oversight 9) Emergency Preparedness - Pandemic 10) Infection Control & Antibiotic Stewardship Education - Staff and Residents 11) Mandatory Reporting and Communication (may include residents, families, staff, health departments, physicians etc.) 12) Regulatory Compliance 13) Quality Assurance Committee 14) Performs other duties as assigned. To perform this job successfully, an individual must be able to perform each essential duty satisfactorily. An untitled document, provided by the Administrator on 4/21/26 at 9:37 a.m., indicated the following: .IP Hours of Work - Designated IP hours per week can vary based on the facility and its resident population. Therefore, the amount of time required to fulfill the role must be at least part-time and should be determined by the facility assessment, conducted according to S483.71, to determine the resources it needs for its IPCP, and ensure that those resources are provided for the IPCP to be effective. Based upon the assessment, facilities should determine if the individual functioning as the IP should be dedicated solely to the IPCP.</p>

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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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>Based on observation and interviews, the facility failed to ensure a safe environment for residents when steam tables were left on and unattended in the main dining room. This deficient practice had the potential to affect 9 cognitively impaired and independently mobile residents of 62 residents residing in the facility. Findings include: During an observation, on 4/16/26 at 10:30 a.m., a four compartment steam table in the main dining room, between D and E halls, was left unattended and on the high setting. Steam was noted coming from all four compartments. The two chains blocking off the cooking area of the dining room were down, allowing for direct access to both sides of the steam table. During an interview, on 4/16/26 at 10:36 a.m., the Dietary Manager walked into the serving area of the dining room and indicated the chains were down and should be up after each meal service. The steam tables were turned off after meal service, and staff turned them back on about an hour and twenty minutes before each meal service, so they were hot during the meal. Only dietary staff and nursing staff were permitted in the cooking area of the dining room. He had turned on the steam tables about 35-40 minutes ago when he brought up the enclosed hall carts to get ready for lunch service. A sign hanging on a pillar in the dining room, titled Mealtimes, indicated lunch meal service was at 12:30 p.m. During an observation, on 4/20/26 at 9:27 a.m., the four compartment steam table in the main dining room between D and E halls was unattended and on the high setting. Steam was noted coming from all four compartments. When the lids were removed, water was seen simmering in the holding pans. The two chains blocking off the cooking area of the dining room were down, allowing access to both sides of the steam table. On 4/20/26 at 9:30 a.m., three dietary staff members walked past the dining room pushing a three-shelf wheeled cart. The staff members did not put the chains up. On 4/20/26 at 9:30 a.m., a CNA walked by the dining room while the chains remained down. On 4/20/26 at 9:31 a.m., two dietary staff members walked past the dining room pushing a wheeled cart. The dining room chains remained down. During an interview, on 4/20/26 at 10:01 a.m., the Administrator indicated the steam tables in the dining room should be turned off when not in use. Dietary staff came up 15-20 minutes before meals to turn the steam tables back on. If the steam tables were on, the chains should be up. During a written electronic communication (e-mail), on 4/21/26 at 2:20 p.m., the Administrator indicated nine residents were cognitively impaired and independently mobile between the two halls. A current facility policy, dated 2020, Untitled, provided by the Administrator, on 4/21/26 at 3:30 p.m., indicated the following: .4. Once the steam table is in the serving location, it is plugged in to help maintain food temperatures and must be continually staffed by an employee. 5. A steam table is never left unattended in any area readily accessible to residents 410 IAC (Indiana Administrative Code) 16.2-3.1-19(f)</p>		

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<p>F 0582</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered.</p> <p>Based on observation and interview, the facility failed to provide notification of Medicare Non-Coverage (NOMNC) at the end of Medicare A-covered services for 1 of 3 residents reviewed for beneficiary notification. (Resident 7). Finding includes: On 4/15/26 at 12:37 p.m., the Skilled Nursing Facility (SNF) Beneficiary Notification Review Forms were reviewed and indicated the following: Resident 7 was admitted to Medicare Part A Skilled Services on 11/11/25. The last covered day of Part A services was 1/25/26. The facility/ provider initiated the discharge from Medicare Part A services when benefit days were not exhausted. A NOMNC was not provided since the beneficiary initiated the discharge. The resident transferred to a local area hospital on 1/18/26 and returned to the facility on 1/23/26 under Medicare Part A services. Resident 7 had an Occupational Therapy visit on 1/23/26. A Therapy Payor Verification Form, dated 1/23/26, indicated Resident 7's payor source was Medicare Part A. Resident was discharged from Medicare Part A on 1/25/26. The SNF Notice of Medicare Non-Coverage (NOMNC) was not provided to the resident or resident's representative. During an interview, on 4/21/26 at 9:38 a.m., the Administrator indicated Resident 7 readmitted to the facility and was Medicaid pending. The NOMNC would be discussed 48 hours before the resident discharged. The facility could not find where Resident 7 was provided with a NOMNC. During an interview, on 4/22/26 at 9:57 a.m., the Financial Coordinator indicated the facility discussed during a team meeting that the resident would be discharged off Medicare Part A Services while he was at the hospital. When the resident readmitted to the facility, he would no longer be skilled service. The Financial Coordinator did not speak with the resident or his representative regarding discontinuing services. She assumed since Resident 7 did not discharge home, and stayed in the facility, he did not need a NOMNC completed. During an electronic written correspondence (e-mail), on 4/21/26 at 3:30 p.m., the Administrator indicated the facility did not have a policy regarding Beneficiary Notification and the facility followed Indiana State Regulations. 410 IAC (Indiana Administrative Code) 16.2-3.1-4(f)(3)</p>

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<p>F 0605</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function.</p> <p>Based on observation, record review, and interview, the facility failed to ensure a resident was free from the use of a chemical restraint related to the use of an antipsychotic medication without clinical indication and without the development of non-pharmacological interventions for 1 of 5 residents reviewed for unnecessary medications. (Resident 21) Findings include: During an observation on 4/17/26 at 12:02 p.m., Resident 21 was in his room, asleep in bed. The room was dark and the television was playing. On 4/20/26 at 9:02 a.m., Resident 21 was lying in bed watching television. He indicated he was comfortable at the facility. The staff treated him kindly. Resident 21's clinical record was reviewed on 4/16/26 at 3:37 p.m. Diagnoses included personal history of traumatic brain injury (TBI), major depressive disorder, recurrent, psychotic disorder with hallucinations due to a known physiological condition, Alzheimer's disease with early onset, and dementia in other diseases classified elsewhere, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. Current physician orders included risperidone (antipsychotic) 0.25 mg give one tablet by mouth one time a day for delusional disorder (3/19/26), monitor for dry mouth, constipation, blurred vision, disorientation/confusion, difficulty urinating, hypotension, dark urine, yellow skin, nausea and vomiting, lethargy, drooling, extrapyramidal symptoms (tremors, disturbed gait, increased agitation, restlessness, involuntary movement of mouth or tongue) due to antipsychotic medication use (5/5/25), lorazepam 0.5 mg give one tablet by mouth every morning and at bedtime for anxiety and restlessness related to generalized anxiety disorder (6/21/25), and sertraline 100 mg give one table by mouth one time a day for depression related to major depressive disorder (5/25/25). A quarterly Minimum Data Set (MDS) assessment, dated 2/25/26, indicated Resident 21 was severely cognitively impaired, had moderate depression, did not exhibit delusions, hallucinations, or behaviors, required substantial/maximal assistance for bed mobility, was dependent for toileting and showering, and was dependent for all transfers. Active diagnoses included anxiety and depression. A current care plan, initiated on 5/4/25, indicated Resident 21 used an antipsychotic medication related to depression and anxiety. The goal was Resident 21 was to remain free of psychotropic drug related complications, including movement disorder, discomfort, hypotension, gait disturbance, constipation/impaction or cognitive/behavioral impairment through the next review date. Interventions included to administer psychotropic medications as ordered by the physician, monitor for side effects and effectiveness every shift, consult with pharmacy - MD to consider dosage reduction when clinically appropriate at least quarterly, monitor/document/report, as needed, any adverse reactions of psychotropic medications (unsteady gait, tardive dyskinesia, extrapyramidal symptoms, frequent falls, refusal to eat, difficulty swallowing, dry mouth, depression, suicidal ideations social isolation, blurred vision, diarrhea, fatigue, insomnia, loss of appetite, weight loss, muscle cramps, nausea and vomiting, behavior symptoms not usual to the person, monitor/record occurrence of behavior symptoms such as pacing, wandering, disrobing, inappropriate response to verbal communication, violence/aggression towards staff/others, and document per facility protocol. A Level 2 Pre-admission Screen and Resident Review (PASRR), dated 4/25/25, indicated no previous inpatient psychiatric admissions or outpatient mental health services. No history of significant mental illness, intellectual disability or developmental disability. Past psychosis included delusions and hallucinations. A Social Services note, dated 5/1/25 at 11:43 a.m., indicated Resident 21's communication issues were related to a history of traumatic brain injury (TBI). Resident 21 had difficulty making decisions. There was no evidence of an acute change in mental status from the resident's baseline. The resident was not easily distracted and did not have difficulty keeping track of the conversation. He did not exhibit disorganized or incoherent thinking (rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject. There were no indicators of psychosis, and no examples of hallucinations and/or delusions within the (continued on next page)</p>		

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<p>F 0605</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>lookback period. The resident exhibited no behavioral symptoms. He did not reject evaluation or care (e.g., bloodwork, taking medications, assistance with activities of daily living). A 5/13/25 pharmacy recommendation indicated there did not appear to be an appropriate diagnosis listed in (the electronic health record) or on the eMAR that indicated the need for risperidone. Appropriate diagnoses to support antipsychotic use included schizophrenia, schizo-affective disorder, psychotic mood disorders (including mania and depression with psychotic features), acute psychotic episodes, brief reactive disorders, schizophreniform disorder, atypical psychosis, delusional disorder, dementing disorder with behavioral symptoms, Tourette's disorder, Huntington's Disease, organic mental syndromes with associated psychotic and/or agitated features. Risperidone was not indicated for depression. Please consider discontinuation of antipsychotic therapy at this time or add a supporting diagnosis. The provider did not respond to the recommendation. A psychiatry initial consultation note, dated 5/16/25 at 1:00 p.m., indicated Resident 21 was receiving risperidone 0.5 mg daily for depression related to diagnoses of depression and anxiety. The resident was in a motor vehicle accident (MVA) resulting in a TBI and the death of his mother. He had been feeling anxious and depressed related to his situation. He denied hallucinations or delusions. He refused to get out of bed except for therapy and was self-isolating. He was on one antipsychotic, risperidone 0.5 mg daily, and admitted to the facility on the medication. The NP discontinued his escitalopram (an antidepressant) and started sertraline 50 mg daily for seven days, then increase to 100 mg daily for better control of depressive symptoms. The NP started lorazepam 0.5 mg every 12 hours as needed for 14 days for anxiety. The NP continued the risperidone 0.5 mg daily with a goal to continue to gradually reduce and then discontinue at a future visit. A psychiatry progress note, dated 6/5/25 at 1:00 p.m., indicated the resident was receiving risperidone 0.5 mg daily for depression related to depression and anxiety disorders, and sertraline 100 mg daily for depression. Resident 21's anxiety and depression had improved on sertraline and lorazepam since the last visit. No other concerns were voiced related to mood or new behaviors. A 6/17/25 pharmacy recommendation indicated the resident had a diagnosis of delusional disorder listed in a progress note; however, this was not an active diagnosis in (the electronic health record) diagnosis list. The pharmacist requested an update to the clinical record. A progress note, dated 7/7/25 at 2:13 p.m., indicated Resident 21 was receiving risperidone 0.5 mg daily for depression. A behavioral health note, dated 7/15/25 at 1:00 p.m., indicated facility staff reported no new concerns about mood or behavior. A psychiatry progress note, dated 8/7/25 at 1:00 p.m., indicated Resident 21 received risperidone 0.5 mg for delusional disorders related to depression and anxiety. Staff and the Social Services Director (SSD) reported the resident had been at baseline since the last encounter. He accepted care and medications as scheduled. There were no concerns related to mood. A 30-Day Follow-Up note, dated 8/12/25 at 11:57 a.m. indicated Resident 21 received risperidone 0.5 mg daily for delusional disorders related to depression and anxiety (7/8/25). A psychiatry progress note, dated 9/18/25 at 1:00 p.m., indicated Resident 21 received risperidone 0.6 mg daily for delusional disorders related to depression and anxiety. Staff and SSD reported Resident 21 had been baseline since last encounter. He accepted care and medications as scheduled. No concerns related to mood, oral intakes, or sleep pattern. A behavioral health progress note, dated 10/1/25 at 1:00 p.m., indicated Resident 21 had past psychiatric diagnoses of depression, anxiety, and delusions and hallucinations prior to admitting to the facility. Facility staff reported no new concerns. The behavioral health progress note did not define the delusions and hallucinations the resident had experienced prior to admission. A psychiatry progress note, dated 10/16/25 at 1:00 p.m., indicated staff and the SSD reported the resident had been at baseline since last encounter. He accepted care and medications as scheduled. No concerns related to mood, oral intakes, or sleep pattern were reported. A behavioral health progress note, dated 11/18/25, indicated Resident 21 was calm and cooperative. He smiled and told the clinician he was doing well. He denied concerns about his mood. Facility staff reported no changes in mood or behavior. A psychiatry progress note, dated 11/20/25 at 1:00 p.m., indicated Resident 21 received risperidone 0.5 mg daily. The resident was (continued on next page)</p>		

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<p>F 0605</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>admitted to the facility with the risperidone. A psychiatry progress note, dated 12/18/25 at 1:00 p.m., indicated Resident 21 received risperidone 0.5 mg daily. Staff and the SSD reported the resident had been baseline since the last encounter. He accepted care and medications as scheduled. No concerns related to mood, oral intakes, or sleep pattern. A 1/9/26 pharmacy recommendation indicated the resident had an order for risperidone 0.5 mg. However, psychiatric progress notes indicated the resident was to receive a GDR of risperidone to 0.25 mg daily on 12/18/25. The provider responded and clarified the order was for risperidone 0.25 mg daily. A psychiatry progress note, dated 1/9/26, indicated Resident 21 was being seen for consideration of a gradual dose reduction (GDR) for risperidone 0.5 mg. Resident 21 was appropriately dressed and groomed for the day. He had no concerns related to his mood. He was pleasant and calm. Staff and the SSD reported Resident 21 had been at baseline since the last encounter. There were no concerns related to mood, oral intakes, or sleep patterns. The NP indicated to continue risperidone 0.25 daily. The GDR was contraindicated because the resident had an acute medical illness at that time. A GDR at that time could impair the resident's function and/or cause psychiatric instability and risk decompensation. There was no clinical indication for a reduction at that time. The resident had a recent GDR of medication in December 2025. The NP would re-evaluate the need to GDR the risperidone at the next GDR visit. Nursing staff were to document any new or worsening moods/behaviors and notify psychiatric services. A communication with prescriber note, dated 1/14/26 at 4:20 p.m., indicated the psychiatric NP reviewed the consultant pharmacist recommendation to consider a GDR for risperidone 0.5 mg daily. The NP declined and did not provide a rationale. A progress note, dated 2/4/26, indicated Resident 21 denied any changes or concerns. He continued to eat and sleep normally. He continued to isolate himself in his room, which was his preference. Facility staff reported no new concerns. A progress note, dated 2/27/26, indicated staff and the Social Services Director (SSD) reported Resident 21 had been baseline since the last encounter. There were no reports or concerns related to mood, oral intakes, or sleep pattern. The resident was pleasant and calm. A progress note, dated 3/4/26, indicated the NP met with Resident 21 for a routine follow-up. Resident 21 was calm, friendly, well-groomed, and in no apparent distress. He was smiling and joked with the clinician. He reported he had been doing fine and his mood was good. Facility staff reported no new concerns about mood or behavior. The NP suggested non-pharmacological interventions to include cognitive/emotion-oriented interventions (reminiscence therapy, simulated presence therapy, validation therapy), sensory stimulation interventions (aromatherapy, light therapy, massage/touch, music therapy), behavior management (distraction, redirection, and relaxation) techniques, and other psychosocial interventions such as animal-assisted therapy and exercise. The clinical record lacked documentation of the development and implementation of non-pharmacological interventions, sensory stimulation interventions, behavior management techniques, or other psychosocial interventions. A psychiatry progress note, dated 4/2/26 at 1:00 p.m., indicated Resident 21 was taking risperidone tablet 0.25 mg one time a day for delusional disorder. He was referred to psychiatric services for ongoing management of his anxiety, depression, and mood disorder. Staff reported Resident 21 had been at baseline since the last encounter. He accepted care and medications. He spent most of the time in his room, as was his choice. He was in no distress, appropriately dressed and neatly groomed. He denied concerns during the visit. No reported hallucinations or delusions. Nursing was to monitor/document any clinically significant changes in mood/behaviors (e.g., feeling scared, panic attack, irritability, pacing/fidgeting, excessive worrying, etc.) related to anxiety. Nursing was to monitor/document any clinically significant changes in mood/behaviors (e.g., sadness, anhedonia, tearfulness, hopelessness, isolation in room, feelings of guilt, etc.) related to depression. During an interview with NP 12 on 4/17/26 at 10:02 a.m., she indicated Resident 21 stayed in his room most days. Staff had never reported hallucinations, delusions, or behaviors for Resident 21. Although she did prescribe some of his medications, she did not prescribe his psychotropic medications. During an interview with CNA 10 on 4/21/26 at 11:06 a.m., she indicated she had never seen Resident 21 experiencing hallucinations or (continued on next page)</p>		

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<p>F 0628</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies.</p> <p>Based on interview and record review, the facility failed to provide residents and/or their representatives with written notice of transfer/discharge and bed hold policy for 2 of 3 residents reviewed for hospitalizations (Resident 2 and Resident 70). Findings include: 1. Resident 2's clinical record was reviewed on 4/17/26 at 11:34 a.m. Diagnoses included acute respiratory failure with hypoxia, COPD (chronic obstructive pulmonary disease), chronic kidney disease, and atrial fibrillation (rapid irregular heartbeat). A 12/10/25, quarterly, Minimum Data Set (MDS) assessment indicated the resident was cognitively intact. A progress note, dated 12/14/25 at 9:49 p.m., indicated the resident was sent to the hospital for altered mental status. The resident was difficult to wake up and would not stay awake. He followed commands slowly but returned to sleep. Vital signs were obtained and within normal limits. The hospital was called and given a report of the resident's condition. Two attempts to notify the resident's representative were unsuccessful. A progress note, dated 12/14/25 at 10:18 p.m., indicated the resident's representative was notified and given report at 10:10 p.m. The clinical record lacked review of the notice of transfer/discharge and bed hold policy with the resident or the resident's representative. 2. Resident 70's clinical record was reviewed on 4/20/26 at 8:48 a.m. Diagnoses included acute and chronic respiratory failure with hypoxia, atrial fibrillation, chronic obstruction pulmonary disease, and abnormal finding of the lung field. A 1/5/26, admission, MDS indicated the resident was cognitively intact. A progress note, dated 1/29/26 at 10:50 a.m., indicated the resident was found unresponsive but breathing. The resident had been administered a new medication, lorazepam 0.5 milligrams (mg) at 7:06 a.m., for anxiety and oxycodone-acetaminophen (opiate) 7.5 mg-325 mg at 8:06 a.m. for pain. The NP was notified, and naloxone (rapid acting medication to reverse drug overdose) was given twice per order. Following the second dose of naloxone the resident was responsive to name but reached out, yelled, and was restless. The resident repeatedly attempted to remove the oxygen mask with increasing shortness of breath. The NP was notified, and an order was received to send to the hospital for evaluation. The resident's representative was present at the bedside and agreed. Paperwork, current medication list, and code status were sent with the resident. The clinical record lacked review of the notice of transfer/discharge and bed hold policy with the resident or the resident's representative. A notice of transfer/discharge form and bed hold policy form, dated 1/29/26, had a box marked that the resident was unable to sign. The form was signed by the Social Services Director. During an interview on 4/22/26 at 11:18 a.m., LPN 17 indicated when a resident was sent to the hospital, the face sheet, which included the medication list and diagnoses, a transfer form which included the resident's condition, and the code status were sent to the hospital. When the resident was alert and oriented, the transfer/discharge notice and bed hold policy were discussed and signed. If the resident was unable to sign, then the family was notified. The facility kept the transfer/discharge form and bed hold policy form. A progress note about the transfer to the hospital should include the notification of the physician, the orders received, the hospital to which the resident was transferred, the notification of the resident and/or resident representative of the resident's transfer, the transfer/discharge form, and bed hold policy. During an interview, on 4/22/26 at 11:50 a.m., LPN 18 indicated when a resident went to the hospital, an order was received from the provider. If the resident was not cognitively intact, the resident's representative was notified. The medication list, face sheet, and bed hold policy were sent with the resident. Report was given to the emergency medical technicians and to the receiving hospital. The transfer/discharge notice and bed hold policy were reviewed with the resident. If the resident was unable to sign, the notice and policy were reviewed with the resident's representative. The review of the transfer/discharge notice and the bed hold policy was documented. During an interview, on 4/22/26 at 12 p.m., the DON indicated she was unable to locate where the transfer/discharge notice and bed hold policy were reviewed with Resident 2, Resident 70, or their (continued on next page)</p>		

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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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<p>F 0628</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>representatives. She indicated a notice of transfer/discharge form with the bed hold policy, dated 1/29/26, had a box marked that the resident was unable to sign for Resident 70 and was signed by the SSD. During an interview, on 4/22/26 at 12:34 p.m., the SSD indicated she had signed the notice of transfer/discharge and bed hold form for Resident 70. She was new at the time and did not remember what happened. Usually, the nurses signed the form with the residents. A current facility policy, revised 8/14/17, provided by the Administrator on 4/21/26 at 3:29 p.m., titled Notice of Transfer and Discharge, indicated the following: .Notify the resident and the resident's representative for the move in writing and in a language they understand. 410 IAC (Indiana Administrative Code) 16.2-3.1-12(a)(6)(i)410 IAC 16.2-3.1-12(a)(6)(ii)410 IAC 16.2-3.1-12(a)(6)(iii)410 IAC 16.2-3.1-12(a)(25)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>Based on interview and record review, the facility failed to ensure shift to shift narcotic count and reconciliation was completed to mitigate risk of misappropriation for 2 of 3 carts reviewed for medication reconciliation. (D1 Hall and E1 Hall) Findings include: 1. During a medication storage observation of the D1 Hall medication cart, on 4/16/26 at 12:15 p.m., accompanied by LPN 14, the Shift change controlled substance inventory count sheet and the Pharmscript Controlled Drug Count Sheets were reviewed and the following dates lacked shift to shift count and reconciliation signatures of controlled medications: April 2026: April 5: day shift, evening shift and night shift April 6: evening and night shift April 7: evening shift April 8: evening shift April 9: evening shift April 10: evening shift During an interview at the time of observation, LPN 14 indicated the narcotic count sheets were incomplete due to missing shift to shift signatures. 2. During a medication storage observation of the E1 Hall medication cart, on 4/16/26 at 12:06 p.m., accompanied by QMA 15, the Pharmscript Controlled Drug Count Sheet was reviewed and the following dates lacked shift to shift count and reconciliation signatures of controlled medications: April 2026: April 5: evening shift April 6: night shift April 7: night shift April 13: night shift During an interview, on 4/16/26 at 3:55 p.m., the DON indicated the controlled narcotic sheets were incomplete. A current facility policy, dated 11/2012 and revised on 11/2017, titled Narcotic/Controlled Substances- Counting, provided by the Administrator, on 4/21/26 at 3:30 p.m., indicated the following: .Always participate in counting of the controlled substances at the beginning and ending of your shift. 16. Sign name, time and date of completed count 410 IAC (Indiana Administrative Code) 16.2-3.1- 25(b)(3)</p>		

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident's drug regimen must be free from unnecessary drugs.</p> <p>Based on interview and record review, the facility failed to ensure non-pharmacological interventions were developed and implemented for a resident prior to ordering an antipsychotic medication for insomnia for 1 of 5 residents reviewed for unnecessary medications. (Resident 3) Finding includes: Resident 3's clinical record was reviewed on 4/17/26 at 10:45 a.m. Diagnoses included post-traumatic stress disorder, bipolar disorder, anxiety disorder, and depression. Orders included amitriptyline (antidepressant) 50 mg at bedtime for depression (3/20/26 - 4/6/26), amitriptyline 50 mg at bedtime related to post-traumatic stress disorder (PTSD), bipolar disorder, anxiety disorder, and depression (4/10/26), trazodone (antidepressant) 50 mg at bedtime for insomnia related to depression and insomnia (3/20/26 - 4/6/26), trazodone (antidepressant) 50 mg at bedtime for insomnia (4/10/26), quetiapine (antipsychotic) 25 mg every 24 hours as needed (PRN) for insomnia related to bipolar disorder, anxiety disorder, and depression for 14 days (3/20/26 - 4/3/26), and quetiapine 25 mg every 24 hours PRN for insomnia (4/9/26). A 2/14/26, admission, Minimum Data Set (MDS) assessment indicated the resident was cognitively intact. She indicated she had trouble falling or staying asleep for 7-11 days of the 14 days assessment period. No behaviors were marked. She indicated she had frequent moderate pain that occasionally affected sleep. She received insulin, antidepressant, anticoagulant, antibiotic, diuretic, opioid, hypoglycemic, and antiplatelet medications. A 3/25/26, significant change, MDS assessment indicated the resident was cognitively intact. She indicated she had trouble falling or staying asleep for 7-11 days of the 14 days assessment period. No behaviors were marked. She indicated she had frequent moderate pain that occasionally affected sleep. She received insulin, antidepressant, anticoagulant, antibiotic, diuretic, opioid, hypoglycemic, and antiplatelet medications. A current care plan, dated 2/11/26, indicated the resident had episodes of insomnia. Interventions included administer medications per order (2/11/26) and monitor causes for insomnia: medications, caffeine, over stimulation, depression, and anxiety (2/11/26). The clinical record lacked individualized identification of the resident's insomnia symptoms related to bipolar disorder and did not indicate non-pharmacological interventions to be implemented prior to administration of additional medications. A current care plan, dated 2/11/26, indicated the resident was at risk for mood fluctuation related to anxiety disorder, bipolar disorder, depression, and PTSD. Interventions included administer medications per order and monitor/document for side effects (2/11/26) and observe for signs and symptoms of mania or hypomania racing thoughts or euphoria, increased irritability, frequent mood changes, pressured speech, flight of ideas, marked change in need for sleep, and agitation or hyperactivity (2/11/26). A progress note, dated 3/20/26 at 3:30 p.m., indicated the resident had returned from the hospital. Discharge orders from the hospital on 3/20/26 included the order for quetiapine 25 mg at bedtime daily for insomnia. A progress note, dated 3/23/26 at 5:48 p.m., indicated the resident was seen by the nurse practitioner (NP) for readmission. She indicated the resident received trazodone 50 mg at bedtime for insomnia and quetiapine 25 mg every 24 hours as needed for insomnia for 14 days at bedtime. A progress note, dated 3/25/26 at 9:36 a.m., for date of service 3/24/26, indicated the resident was seen by the physician for readmission. The physician indicated the resident continued to have frequent pain management. The resident was crying because of being in pain. The resident stated her pain medicine adequately controlled her pain for now. Medications were reviewed. A progress note, dated 3/27/26 at 8:32 a.m., indicated the resident was seen by the NP for reports of left wrist pain from a recent bruise. The resident stated her pain was not well controlled and requested a pain medication increase. The plan indicated the oxycodone-acetaminophen dosage was increased from 5 mg/ 325 mg to 7.5 mg/325 mg every 6 hour as needed for pain for 48 hours then resume 5 mg/ 325 mg dosage. A progress note, dated 4/9/26 at 10:10 p.m., indicated the resident arrived at the facility from the hospital at 10:02 p.m. A progress note, dated 4/10/26 at 5:01 p.m., indicated the resident was seen by the NP for readmission. The resident denied pain or discomfort. She indicated the resident received quetiapine 25 mg as needed (continued on next page)</p>		

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>for insomnia at bedtime and trazodone 50 mg at bedtime for insomnia. The clinical record lacked indication of the resident's exhibition of behaviors related to bipolar disorder. A review of the medication administration record for March 2026 and April 2026 indicated the resident did not take the as needed quetiapine. A review of the pharmacy recommendations on 4/10/26 indicated the pharmacist recommended adding a stop date not exceeding 14 days from the start of therapy to the quetiapine 25 mg every 24 hours PRN. The NP indicated, on 4/20/26, to discontinue the quetiapine if not used. During an interview, on 4/20/26 at 2:32 p.m., the ADON indicated the resident had an order for the PRN quetiapine upon return from the hospital on 3/20/26 and 4/9/26. She had asked the NP to review the order. The NP had decided to keep the order. During an interview, on 4/20/26 at 4:02 p.m., NP 20 indicated the quetiapine was appropriate for 14 days as the resident had used it in the hospital while in the intensive care unit and on the medical unit. The quetiapine was a typical medication used in the hospital for insomnia. If the resident had used the medication, she would have referred the resident to the psychiatric health provider. During an interview, on 4/22/26 at 11:27 a.m., LPN 17 indicated the resident got antsy if she did not get medications when she asked for them immediately even when the medications were not yet due and if the resident felt her call light was not answered immediately. The resident sometimes said no one had been in her room for hours, but LPN 17 indicated she knew that statement was not true because she herself had been in resident's room earlier to deliver breakfast, to get her blood sugar, and to discuss when her medications were due. The resident seemed to calm when LPN 17 listened and conversed with her. LPN 17 did not remember the resident having any difficulties with sleeping. The resident took amitriptyline for her bipolar disorder. Since the resident's oxycodone was scheduled every four hours, the resident does not complain of pain anymore. During an interview, on 4/22/26 at 11:32 a.m., QMA 21 indicated she had never heard of the resident having trouble sleeping at night. The resident had been very friendly lately. The resident enjoyed interaction with others. QMA 21 had never seen the resident have any behaviors. During an interview, on 4/22/26 at 11:57 a.m., CNA 10 indicated the resident had not had any behaviors lately. The behavior she had seen in the past were the resident would wake up angry and be unpleasant. Before the resident's first stay in the hospital, the resident occasionally had difficulty with sleeping, but since then she had no problems with sleeping. During an interview, on 4/22/26 at 12:09 p.m., the DON indicated the resident had started the quetiapine in the hospital. She and NP 20 had discussed the quetiapine order. NP 20 indicated the resident had issues in the hospital and wanted to keep the quetiapine order in case the resident had those issues at the facility. NP 20 discontinued the quetiapine on 4/20/26. According to the FDA website, accessed on 4/21/26 at https://www.accessdata.fda.gov/drugsatfda_docs/label/2025/020639s074lbl.pdf, Indications for usage of quetiapine are schizophrenia, bipolar I disorder with manic episodes, and bipolar disorder, depressive episodes. The indications did not include insomnia. A current facility policy, revised 2/1/18, titled Psychotropic Medication - Gradual Dosage Reduction, provided by the Administrator on 4/21/26 at 3:29 p.m., indicated the following Purpose: To ensure that residents are not given psychotropic drugs unless psychotropic drug therapy is necessary to treat a specific or suspected condition as per current standard of practice. 410 IAC (Indiana Administrative Code) 16.2-3.1-48(a)(4)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>Based on observation, interview, and record review, the facility failed to ensure food was prepared and served under safe and sanitary conditions when food was handled with bare hands during a meal service observation. Findings include: During a lunch service observation, on 4/17/26 at 12:37 p.m., the following was observed: Cook 16 picked up a roll with her bare hands before placing it on a resident's plate. [NAME] 16 grabbed a single scoop of mashed potatoes and place them on the food portion of the plate. A ping pong ball - size of mashed potatoes fell off the scoop and onto the handle of the stainless-steel pan. [NAME] 16 scooped up the mashed potatoes from the pan's handle with her bare hand before tossing it back into the pan of mashed potatoes. Cook 16 plated three rolls for three plates with her bare hand before using tongs. During an interview, on 4/17/26 at 1:16 p.m., [NAME] 16 indicated she could have slipped up and touched a piece of bread with her bare hands. She did not recall touching the mashed potatoes with her bare hands. Staff should not touch food with their bare hands. During an interview, on 4/17/26 at 1:19 p.m., the Dietary Manager indicated staff members should not touch food with their bare hands. During an interview, on 4/21/26 at 2:25 p.m., the DON indicated staff should not touch food with their bare hands. A current facility policy, dated 2009, titled Safe Food Preparation and Handling, provided by the Administrator on 4/21/26 at 3:30 p.m., indicated the following: .1. Strict personal hygiene will be followed. Employees will avoid direct contact (i.e.) using bare hands) with ready-to-eat foods. 410 IAC (Indiana Administrative Code) 16.2-3.1-21(i)(3)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>Based on observation, interview, and record review, the facility failed to ensure food was served under safe and sanitary conditions regarding food handling during a meal observation for 1 of 16 residents observed in the dining room. (Resident 49) Findings include: During a lunch observation, on 4/21/26 at 12:42 p.m., the following was observed: CNA 9 assisted Resident 49 with his meal tray. CNA 9 grabbed the top hamburger bun from Resident 49's fish sandwich with her bare hands before she placed the bun on Resident 49's tray. CNA 9 picked up a small plastic container of tartar sauce and asked Resident 49 if he wanted any on his sandwich. Resident 49 declined. CNA 9 put down the small plastic container of tarter sauce, picked up the top bun again with her bare hand and placed it on top of Resident 49's sandwich before walking away from the table. During an interview, on 4/21/26 at 12:46 p.m., CNA 9 indicated she touched Resident 49's hamburger bun with her bare hands. She should not touch any food bare handed. During an interview, on 4/21/26 at 2:25 p.m., the DON indicated staff should not touch food with their bare hands. A current facility policy, dated 2009, titled Safe Food Preparation and Handling, provided by the Administrator, on 4/21/26 at 3:30 p.m., indicated the following: .1. Strict personal hygiene will be followed. Employees will avoid direct contact (i.e.) using bare hands) with ready-to-eat foods. 410 IAC (Indiana Administrative Code) 16.2-3.1-21(i)(3)</p>		