STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155820	A. Building B. Wing	09/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aperion Care Lincoln	1236 Lincoln Ave Evansville, IN 47714

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on observation and interview, the facility failed to report an alleged violation of sexual abuse to the State Survey Agency for 1 of 1 allegation of abuse reviewed. (Resident T)Finding includes:In an anonymous interview, it was indicated that Resident B asked Resident T for sex and to see her breasts, and that Resident T was not capable of giving consent.During an interview on 9/24/25 at 9:24 A.M., the Director of Nursing (DON) indicated that a few weeks prior, a Certified Nurse Aide (CNA) had reported to her that Resident B went into Resident T's room and asked her to be his girlfriend and if she had ever had sex. Resident T responded no and Resident B left. The DON was unable to remember when that incident occurred.During an interview on 9/24/25 at 11:00 A.M., the DON indicated that the CNA also reported to her that Resident T showed Resident B her breasts. She indicated that the incident occurred on or around 8/23/25.During an interview on 9/24/25 at 1:04 P.M., the Administrator indicated he was aware of the incident that occurred between Resident B and Resident T. He was unaware it needed to be reported to the State Survey Agency.During an interview on 9/24/25 at 1:10 P.M., the Regional [NAME] President of Operations indicated that she was aware of the incident that occurred between Resident B and Resident T, but was unaware that it needed to be reported to the State Survey Agency.During an interview on 9/24/25 at 2:27 P. M., the Administrator indicated that the facility did not have a policy related to reporting alleged violations and followed State regulations.This citation relates to Intake 2608809.3.1-28(c)

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on interview and record review, the facility failed to conduct a thorough investigation of an allegation of abuse for 1 of 1 residents reviewed for abuse. (Resident T)Finding includes:In an anonymous interview, it was indicated that Resident B asked Resident T for sex and to see her breasts, and that Resident T was not capable of giving consent.During an interview on 9/24/25 at 9:24 A.M., the Director of Nursing (DON) indicated that a few weeks prior, a Certified Nurse Aide (CNA) had reported to her that Resident B went into Resident T's room and asked her to be his girlfriend and if she had ever had sex. Resident T responded no and Resident B left. She completed a capacity for sexual consent assessment for both residents at that time and told Resident B he could not ask those questions to other residents. She indicated that there was no other documentation surrounding the incident between Resident B and Resident T.During an interview on 9/24/25 at 11:00 A.M., the DON indicated that the CNA also reported to her that Resident T showed Resident B her breasts.During an interview on 9/24/25 at 1:04 P.M., the Administrator indicated he was aware of the incident that occurred between Resident B and Resident T. He indicated both residents were interviewed and the event was discussed in morning meeting following the event, but there was no documentation about the incident or the investigation.During an interview on 9/24/25 at 1:10 P.M., Regional [NAME] President of Operations indicated that the residents were determined to have capacity to consent but was unsure how the facility determined if someone was cognitively able to give consent. She indicated that she talked with Resident T but she was not able to provide any documentation related to an investigation of the incident.On 9/24/25 at 2:27 P.M., the Administrator provided a current Sexuality-Capacity to Consent Determination policy, revised 7/15/24, that indicated The facility will conduct an investigation and protect the resident from non-consensual sexual relations anytime the facility has reason to suspect that the resident does not wish to engage in sexual activity or may not have the capacity to consent . During the course of the investigation of an allegation of resident sexual abuse or other situation as warranted, the Interdisciplinary Team shall assess and make a determination of whether the sexual activity was consensual on the part of the resident(s) and document the findings of the assessment in a progress note and/or in the plan of care. This citation relates to Intake 2608809.3.1-28(d)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on interview and record review, the facility failed to ensure a resident's wound treatments were completed as ordered for 1 of 3 resident's reviewed for wounds. (Resident C) Finding includes:On 9/23/25 at 1:39 P.M., Resident C's clinical record was reviewed. Resident C's diagnoses included, but were not limited to, type 2 diabetes mellitus without complications. The most recent Minimum Data Set (MDS) Assessment, dated 7/21/25, indicated Resident C was cognitively intact, and had a surgical wound. Physician orders included, but were not limited to: Wound vac to be changed every three days; Start Date 8/8/25 The electronic treatment administration record indicated Resident C's wound vac was scheduled to be changed on the following days in September 2025, but was not changed:9/7/259/10/25 During an interview on 9/24/25 at 12:32 P.M., the Director of Nursing indicated Resident C's wound vac was not changed on 9/7/25 or 9/10/25. On 9/24/25 at 3:02 P.M., the Administrator provided a policy titled Skin Condition Assessment and Monitoring, revised 6/2018, that indicated Physician ordered treatments shall be initialed by the staff on the electronic Treatment Administration Record after each administration. Other nursing measures not involving medications shall be documented in the weekly wound assessment or nurses note.' This citation relates to Intake 2615547. 3.1-35(g)(1)

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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. Based on observation, interview, and record review, the facility failed to ensure a bath or shower was provided for 1 of 3 residents reviewed for bathing. (Resident C) Finding includes:On 9/23/25 at 1:39 P.M., Resident C's clinical record was reviewed. Resident C's diagnoses included, but were not limited to, type 2 diabetes mellitus without complications. The most recent Minimum Data Set (MDS) Assessment, dated 7/21/25, indicated Resident C was cognitively intact and required moderate assistance (staff do part of the work) for bathing. During an observation on 9/23/25 at 1:00 P.M., Resident C indicated that bathing had not been completed or bed linen hadn't been changed in weeks. Resident C had a very pungent sour smell, greasy hair, and long, soiled fingernails. The point of care (POC, a certified nurses aide charting system) indicated Resident C preferred bathing twice weekly in the evenings. Paper and electronic shower records were reviewed for the last 30 days, and indicated Resident C had not received or refused a bath or shower on the following dates: 8/26/259/12/259/19/25 The bathing records indicated Resident C had not had their hair shampooed from 8/26/25 through 9/23/25. On 9/24/25 at 2:27 P.M., the Administrator provided a policy titled Bathing Shower and Tub Bath, revised 1/2018, that indicated A shower, 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. This citation relates to Intake 2588834. 3.1-38(a)(3)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide necessary treatment and services for 1 of 3 residents reviewed for behavior management. An incident with another resident was not documented, a resident's care plan was not updated following the incident, and behaviors were not monitored. (Resident B)Finding includes:In an anonymous interview, it was indicated that Resident B asked Resident T for sex and to see her breasts, and that Resident T was not capable of giving consent.During an interview on 9/23/25 at 1:10 P.M., Resident B indicated that he struggled with mental health disorders due to his time in the war. He indicated that he would like to move to a facility closer to his family.During an interview on 9/23/25 at 1:22 P. M., Resident T indicated that a male resident would open her door sometimes and then leave, but she did not know who it was or recall any specific encounters with any male residents.On 9/23/25 at 2:08 P.M., Resident B's clinical record was reviewed. Diagnoses included, but were not limited to, schizophrenia, generalized anxiety disorder, and unspecified intellectual disabilities. Resident B was admitted to the facility on [DATE].The most current Quarterly Minimum Data Set (MDS) Assessment, dated 8/1/25, indicated Resident B was cognitively intact and had verbal behavior towards others that occurred between one and three days during the lookback period.Current care plans included but were not limited to:I have a history of & recently used illicit substances. I have used the following substances: tobacco, alcohol, excessive prescription medications, cocaine, crack, heroin, methamphetamine (crystal meth) and possibly other illegal substances, per my POA, initiated 7/15/25. Interventions included, but were not limited to, Psychiatric consult as needed.I have potential to be verbally aggressive related to not getting my way, initiated 7/15/25. Interventions included, but were not limited to, Psychiatric/Psychogeriatric consult as indicated and Analyze of key times, places, circumstances, triggers, and what de-escalates behavior and document.The clinical record lacked a care plan that addressed sexual behaviors.The clinical record lacked documentation to indicate Resident B was receiving mental health services.The clinical record, including progress notes, miscellaneous documents, and assessments, lacked documentation about a sexual incident with Resident T, indications that Resident B had sexual behaviors, or that Resident B was monitored for sexual behaviors.On 9/23/25 at 2:56 P.M., Resident T's clinical record was reviewed. Diagnoses included, but were not limited to, Alzheimer's Disease.The most current Quarterly Minimum Data Set (MDS) Assessment, dated 8/29/25, indicated Resident T had moderate cognitive impairment and had no behaviors during the lookback period.A psychiatric encounter progress note, dated 8/29/25, indicated Pt (patient) was involved in an incident with another resident recently. She did not remember nor does she appear in any type of distress.The clinical record, including progress notes, care plans, miscellaneous documentation, and assessment, lacked documentation to indicate details about the incident with another resident that Resident T was involved in. During an interview on 9/24/25 at 8:31 A.M., Certified Nurse Aide (CNA) 9 indicated she had not heard of any residents with sexual behaviors.During an interview on 9/24/25 at 8:37 A.M., the Social Services Director (SSD) indicated that she was not aware of an incident between Resident T and another resident. At that time, she indicated Resident B was trying to transfer to a facility closer to family, but was denied admission to his first choice due to his sexual behaviors. The SSD indicated he did have a history of sexual behaviors, but was unsure if Resident B currently had any sexual behaviors or was being monitored for sexual behaviors at the facility.During an interview on 9/24/25 at 9:24 A.M., the Director of Nursing (DON) indicated that a few weeks prior, a Certified Nurse Aide (CNA) had reported to her that Resident B went into Resident T's room and asked her to be his girlfriend and if she had ever had sex. Resident T responded no and Resident B left. She completed a capacity for sexual consent assessments for both residents at that time and told Resident B he could not ask those questions to other residents. She indicated that since then he had asked staff inappropriate questions about sex, but those behaviors did not get documented. At that time, she indicated that there was no other documentation surrounding the incident between Resident B and Resident T. The DON was unable to remember when that incident occurred.On 9/24/25 at 9:50 A.M., Resident T's clinical record was accessed, and an assessment titled Capacity for Sexual Consent, dated 8/23/25 at 9:38 P.M and locked on 9/24/25 at 9:18 A.M., was reviewed. The assessment indicated Resident T had the capacity to consent to sex, did not wish to have sex, stated he asked me to show my breasts (not like that) and I did, and that family was notified.On 9/24/25 at 9:51 A.M., Resident B's clinical record was accessed, and an assessment label in progress titled Capacity for Sexual Consent, dated 8/23/25, indicated Resident B had

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review, the facility failed to ensure proper storage of medications for 1 of 1 medication rooms reviewed. The medication room, treatment cart, and medication refrigerator were not locked. (First Floor Medication Room)Finding includes: On 9/23/25 at 1:04 P.M., the first floor medication room that contained the Emergency Drug Kit (EDK) was observed unlocked. Inside the room, the treatment cart and the refrigerator that contained insulin, suppositories, and other cold medication was observed unlocked. At that time, Qualified Medication Aide (QMA) 16 indicated that the medication room, treatment cart, and medication refrigerator were all supposed to be locked.On 9/24/25 at 2:27 P.M., the Administrator provided a current Medication Storage policy, revised 7/2/19, that indicated Facility should ensure that all medications and biologicals, including treatment items, are securely stored in a locked cabinet/cart or locked medication room that is inaccessible by residents and visitors.This citation relates to Intake 2615731.3.1-25(m)