

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 06/26/2025
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155820	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/09/2025
NAME OF PROVIDER OR SUPPLIER Aperion Care Lincoln		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	<p>Allow resident to participate in the development and implementation of his or her person-centered plan of care.</p> <p>48147</p> <p>Based on interview and record review, the facility failed to ensure care plan conferences were completed quarterly for 6 of 7 residents reviewed for care plan conferences. (Resident P, Resident S, Resident D, Resident N, Resident B, and Resident F)</p> <p>Findings include:</p> <p>1. On 4/7/25 at 12:35 P.M., Resident P's clinical record was reviewed. Diagnoses included, but were not limited to, cerebral palsy, diabetes mellitus, and major depressive disorder.</p> <p>The most current Quarterly Minimum Data Set (MDS) Assessment, dated 1/25/25, indicated Resident P was cognitively intact.</p> <p>The most current care plan conference was completed on 10/31/24.</p> <p>2. On 4/4/25 at 12:40 P.M., Resident S's clinical record was reviewed. Diagnoses included, but were not limited, to dementia, repeated falls, and major depressive disorder.</p> <p>The most current Quarterly Minimum Data Set (MDS) Assessment, dated 2/20/25, indicated that Resident S had severe cognitive impairment.</p> <p>The most current care plan conference was completed on 11/14/24.</p> <p>3. On 4/7/25 at 2:40 P.M., Resident D's clinical record was reviewed. Diagnoses included, but were not limited to, wedge compression fracture of unspecified lumbar vertebra and unsteadiness on feet.</p> <p>The most current Quarterly Minimum Data Set (MDS) Assessment, dated 2/18/25, indicated Resident D had severe cognitive impairment.</p> <p>The most current care plan conference was completed on 11/7/24.</p> <p>48057</p> <p>4. On 4/4/25 at 12:48 P.M., Resident N's clinical record was reviewed. Diagnosis included, but was not limited to, diabetes mellitus with diabetic polyneuropathy.</p> <p>(continued on next page)</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: Facility ID: 155820	If continuation sheet Page 1 of 49

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<p>F 0553</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The most recent Quarterly MDS assessment, dated 3/20/25, indicated Resident N was cognitively intact.</p> <p>The clinical record lacked a care plan conference since admission.</p> <p>5. On 4/7/25 at 9:24 A.M., Resident B's clinical record was reviewed. Diagnosis included, but was not limited to, hypertensive encephalopathy.</p> <p>The most recent Annual Minimum Data Set assessment, dated 1/3/25, indicated Resident B was moderately cognitively intact.</p> <p>The clinical record lacked a care plan conference since 10/10/24.</p> <p>6. On 4/7/25 at 11:57 A.M., Resident F's clinical record was reviewed. Diagnosis included, but was not limited to, hypertension.</p> <p>The most recent Quarterly MDS assessment, dated 2/17/25, indicated Resident F was cognitively intact.</p> <p>The clinical record lacked a care plan conference since admission.</p> <p>During an interview on 4/8/25 at 1:23 P.M., the Director of Nursing (DON) indicated care plan conferences were held quarterly.</p> <p>On 4/9/25 at 9:19 A.M., care plan conferences held for Resident N, Resident B, and Resident F were requested and not provided.</p> <p>On 4/9/25 at 12:14 P.M., the DON provided a policy titled Comprehensive Care Plans that indicated The resident and/or representative shall be invited to review the plan of care with the interdisciplinary team either in person, via telephone or video conference (if available) at least quarterly.</p> <p>3.1-3(n)(3)</p>		

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<p>F 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice.</p> <p>48147</p> <p>Based on observation, interview, and record review, the facility failed to accommodate a resident's choice of activity for 1 of 2 residents reviewed for choices. A resident's morning care was not completed in time for the resident to attend mass. (Resident P)</p> <p>Finding includes:</p> <p>On 4/4/25 at 9:05 A.M., Resident P indicated she wanted to go to mass, but staff didn't always get her up in time to go. Mass was scheduled daily in the facility at 11:00 A.M.</p> <p>On 4/7/25 at 12:35 P.M., Resident P's clinical record was reviewed. Diagnoses included, but were not limited to, cerebral palsy and major depressive disorder.</p> <p>The most current Quarterly Minimum Data Set (MDS) Assessment, dated 1/24/25, indicated that Resident P was cognitively intact and was dependent on staff (staff does all of the effort) for toileting and bathing.</p> <p>The most current care plan conference was completed on 10/31/24. Care plans were reviewed and updated.</p> <p>A current preferences care plan, initiated 2/12/21, indicated that the resident preferred to get up for the day at 10:00 A.M. or as desired.</p> <p>A current self care deficit care plan, initiated 2/12/21, indicated that the resident required a mechanical lift and the assistance of two staff members for safe transfers.</p> <p>A current activities care plan, initiated 4/15/21, indicated the resident was catholic.</p> <p>On 4/8/25 at 10:14 A.M., CNA 23 indicated that there was never enough staff to get everything done.</p> <p>On 4/8/25 at 11:05 A.M., Resident P was observed in bed in her room. The resident indicated that staff had just completed her shower and she was waiting on staff to get her out of bed with the mechanical lift.</p> <p>On 4/3/25 at 10:05 A.M., the Administrator provided a copy of the Resident Rights, revised 3/15/17, that indicated You have the right to and the facility must promote and facilitate self-determination through support of resident choice, including: the right to choose activities, schedules .consistent with your interests . You have a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility.</p> <p>3.1-3(u)(3)</p>		

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<p>F 0572</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Give residents a notice of rights, rules, services and charges.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48057</p> <p>Based on interview and record review, the facility failed to ensure a resident signed admission paperwork and resident rights and was provided a copy for 1 of 3 residents reviewed for new admissions. (Resident L)</p> <p>Finding includes:</p> <p>During an interview on 4/4/25 at 8:36 A.M., Resident L indicated she was unaware of her rights as a resident in the facility, and had not signed or received an admission packet.</p> <p>On 4/7/25 at 8:55 A.M., Resident L's clinical record was reviewed. Resident L was admitted on [DATE]. Diagnosis included, but was not limited to, malignant neoplasm.</p> <p>The most recent Admission Minimum Data Set (MDS) assessment, dated 3/25/25, indicated Resident L was cognitively intact.</p> <p>An admission packet was signed 3/21/25 by the Social Services Director (SSD) and Resident L.</p> <p>During an interview on 4/8/25 at 1:53 P.M., Resident L stated the signature on the admission packet was not hers.</p> <p>During an interview on 4/9/25 at 9:19 A.M., the SSD indicated residents sign the admission packets electronically and were not provided with a copy unless they request it.</p> <p>On 4/9/25 at 12:14 P.M., the Director of Nursing provided an undated policy titled Documentation Procedures and Guidelines that indicated Each healthcare professional shall be responsible for making their own prompt, factual, concise, entries that are complete, appropriate, and readable.</p> <p>3.1-4(j)</p>		

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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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46758</p> <p>Based on observation, record review, and interview, the facility failed to provide a safe and sanitary environment for residents, staff, and the public for 11 random observations on 5 of 5 days. Offensive odors were detected in public hallways, alcoves and stairwells (throughout 100-unit hallways, in front of chapel, alcoves on 200 unit, outside of rooms [ROOM NUMBERS], Holy Family Nurses Station), dirty showers and resident room floors were observed. (Resident P and Resident D)</p> <p>Findings include:</p> <ol style="list-style-type: none"> On 4/3/25 at 9:30 A.M., during a random observation, the smell of urine was observed on the first floor outside of the chapel. On 4/3/25 at 11:35 A.M., during a random observation the strong smell of urine was observed outside of room [ROOM NUMBER] and 113. On 4/4/25 at 10:03 A.M., during a random observation, the strong smell of urine was observed in the hallway outside of the chapel. On 4/7/25 at 8:50 A.M., during a random observation, the strong smell of urine was observed in the hallway in front of the chapel and in the hallways throughout the 100 unit. On 4/8/25 at 9:10 A.M., during a random observation the strong smell of urine was observed in hallways throughout the 100 unit. On 4/9/24 at 8:40 A.M., during a random observation, the strong smell of urine was observed in the first-floor stairwell and coming onto the hallway in front of the chapel. On 4/9/25 at 8:45 A.M., during a random observation, the strong smell of urine was observed in the hallway near Holy Family Nurses Station. On 4/9/25 at 9:06 A.M., during a random observation, the smell of feces was observed in alcoves throughout the second floor. <p>48147</p> <p>9. In an interview on 4/4/25 at 9:13 A.M., Resident P indicated that staff did not clean her room daily. At that time, brown dried mud was observed on the floor by the bathroom door.</p> <p>On 4/8/25 at 11:05 A.M., Resident P's room was observed to have brown mud stains on the floor by the bathroom door and the shower floor was dirty.</p> <p>10. In an interview with a family member on 4/3/25 at 2:30 P.M., it was indicated that Resident D's room was not cleaned enough and they would find food crumbs behind the drawers when visiting.</p> <p>(continued on next page)</p>		

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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>On 4/8/24 at 2:40 P.M., Resident D's room was observed to have food crumbs along the wall. The bathroom floor was sticky by the shower and the shower floor was dirty.</p> <p>On 4/8/25 at 2:45 P.M., Housekeeper 11 indicated that there was not a daily cleaning list. She indicated she was told to clean the resident's sink and toilet, mop the floors if they were dirty, and take the trash out daily.</p> <p>During an interview on 4/9/25 at 3:03 P.M., the Director of Nursing (DON) indicated there should be no offensive smells in the building.</p> <p>On 4/9/25 at 12:14 P.M., the DON provided a current, non-dated policy Housekeeping Services Policy. The policy indicated . it was the policy of the facility to maintain a clean, odor free, environment in all health care and public areas, which meet the sanitation needs of the facility for a .clean .comfortable environment .</p> <p>On 4/9/24 at 12:14 P.M., the Director of Nursing (DON) provided a current undated Housekeeping Services Policy that indicated The department shall routinely clean the environment of care, using accepted practices, to keep the facility free from offensive odors, the accumulation of dust, rubbish, dirt and hazards.</p> <p>This citation related to Complaint IN00456840.</p> <p>3.1-19(f)</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>48147</p> <p>Based on interview and record review, the facility failed to ensure the Minimum Data Set (MDS) Assessment was completed accurately for 1 of 1 residents reviewed for weight loss. (Resident S)</p> <p>Finding includes:</p> <p>On 4/4/25 at 12:40 P.M., Resident S's clinical record was reviewed. Diagnoses included, but were not limited to, dementia, diabetes mellitus, and dysphagia.</p> <p>The most current Annual Minimum Data Set (MDS) Assessment, dated 2/5/25, indicated Resident S had severe cognitive impairment, required setup assistance from staff for eating, weighed 179 pounds (lbs), and had no weight loss.</p> <p>The most current Quarterly MDS Assessment, dated 2/20/25, indicated Resident S had severe cognitive impairment, required setup assistance from staff for eating, weighed 132 lbs, and had no weight loss.</p> <p>A review of the weights and vitals tab indicated Resident S was weighed on the following days:</p> <ul style="list-style-type: none"> - 1/3/25 - 179.3 lbs standing - 2/18/25 - 131.7 lbs wheelchair (a 26.55% weight loss) <p>On 4/8/25 at 2:51 P.M., CNA 18 weighed Resident S. The resident weighed 162.8 lbs including the wheelchair weight. The wheelchair's weight was 39.5 lbs. CNA 18 confirmed Resident S currently weighed 123.3 lbs (a 6.38% weight loss since 2/18/25 and a 31.23% weight loss since 1/3/25).</p> <p>On 4/9/25 at 9:19 A.M., the MDS Coordinator indicated that the resident had a weight loss and it should have been coded as such on the Quarterly MDS Assessment.</p> <p>On 4/9/25 at 12:50 P.M., the Director of Nursing (DON) indicated the facility followed the Resident Assessment Instrument (RAI) Manual as a policy for MDS coding.</p> <p>3.1-31(d)</p>		

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F 0659 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	<p>Provide care by qualified persons according to each resident's written plan of care.</p> <p>48057</p> <p>Based on record review and interview, the facility failed to ensure Qualified Medication Aides (QMA) practiced within the QMA scope of practice for 2 of 5 residents reviewed for unnecessary medications. (Resident U and Resident P)</p> <p>Findings include:</p> <p>1. On 4/7/25 at 12:29 P.M., Resident U's clinical record was reviewed. Diagnosis included, but was not limited to, type 2 diabetes mellitus.</p> <p>The most recent Admission Minimum Data Set (MDS) assessment, dated 3/24/25, indicated Resident U was moderately cognitively intact.</p> <p>Physician orders included, but were not limited to:</p> <p>Hydrocodone-acetaminophen (pain medication) oral tablet 7.5-325 mg (milligrams) give one tablet by mouth every four hours as needed for pain for 30 days; Start date 3/18/25.</p> <p>The following days indicate a QMA administered Hydrocodone-acetaminophen 7.5-325 mg tablet without prior authorization from a nurse:</p> <p>- 3/24/25 7:02 P.M.</p> <p>- 3/28/25 9:37 A.M.</p> <p>- 3/29/25 3:41 P.M.</p> <p>48147</p> <p>2. On 4/7/25 at 12:35 P.M., Resident P's clinical record was reviewed. Diagnoses included, but were not limited to, cerebral palsy, diabetes mellitus, and pain.</p> <p>The most current Quarterly Minimum Data Set (MDS) Assessment, dated 1/24/25, indicated Resident P was cognitively intact and received insulin and an opioid during the 7-day look back period.</p> <p>Current physician orders included, but were not limited to:</p> <p>- Admelog SoloStar (a fast-acting insulin) 100 units per milliliter (ml) solution - Inject as per sliding scale: 0 - 140 = 0;</p> <p>141 - 180 = 2;</p> <p>181 - 240 = 4;</p> <p>241 - 300 = 6;</p> <p>(continued on next page)</p>		

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<p>F 0659</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>301 - 350 = 8;</p> <p>351 - 400 = 10;</p> <p>401 - 450 = 12 re-check in one hour, subcutaneously before meals and at bedtime related to diabetes mellitus, dated 1/1/25</p> <p>- Hydrocodone-acetaminophen (an opioid pain medication) tablet 5-325 milligrams (mg) - Give one tablet by mouth every four hours as needed (PRN) for moderate pain, dated 12/31/24.</p> <p>- Hydrocodone-acetaminophen tablet 5-325 mg - Give two tablets by mouth every four hours PRN for severe pain, dated 12/31/24</p> <p>- Excedrin (a pain medication) Migraine Oral Tablet 250-250-65 mg (Aspirin-Acetaminophen-Caffeine) - Give one tablet by mouth every 24 hours PRN for migraine, dated 3/19/24</p> <p>Tylenol (a pain medication) Extra Strength Tablet 500 mg - Give two tablets by mouth every eight hours PRN for pain, dated 8/28/23</p> <p>The Medication Administration Record (MAR) for March and April 2025 was reviewed.</p> <p>Qualified Medication Aide (QMA) 5 administered Admelog insulin on the following days:</p> <p>- 3/28/25 7:00 A.M. dose</p> <p>- 4/2/25 8:00 P.M. dose</p> <p>- 4/3/25 8:00 P.M. dose</p> <p>QMA 5 administered a PRN dose of hydrocodone-acetaminophen without prior authorization from a nurse on 4/3/25 5:12 P.M.</p> <p>QMA 5 administered a PRN dose of Tylenol without prior authorization from a nurse on 3/28/25 at 12:04 P.M.</p> <p>QMA 3 administered a PRN dose of hydrocodone-acetaminophen without prior authorization from a nurse on the following days:</p> <p>- 3/2/25 at 9:47 A.M.</p> <p>- 3/11/25 at 9:29 A.M.</p> <p>- 3/18/25 at 6:56 A.M.</p> <p>- 3/20/25 at 7:03 A.M.</p> <p>- 3/27/25 at 8:27 A.M.</p> <p>(continued on next page)</p>		

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F 0659 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	<p>- 3/31/25 at 6:39 A.M.</p> <p>QMA 15 administered a PRN dose of hydrocodone-acetaminophen without prior authorization from a nurse on the following days:</p> <p>- 3/4/25 at 2:58 P.M.</p> <p>- 3/19/25 at 8:18 P.M.</p> <p>- 3/20/25 at 7:21 P.M.</p> <p>- 3/21/25 at 7:19 P.M.</p> <p>- 3/24/25 at 8:27 P.M.</p> <p>- 4/4/25 at 7:26 P.M.</p> <p>QMA 15 administered a PRN dose of Excedrin without prior authorization from a nurse on the following days:</p> <p>- 3/6/25 at 8:04 P.M.</p> <p>- 3/13/25 at 4:00 P.M.</p> <p>On 4/8/25 at 9:22 A.M., the Director of Nursing (DON) indicated that the corporate policy of the facility did not allow QMAs to administer insulin even if they were insulin certified.</p> <p>On 4/9/25 at 9:00 A.M., the QMA Scope of Practice was reviewed. It indicated Administer previously ordered pro re nata (PRN) medication only if authorization is obtained from the facility's licensed nurse on duty or on call. If authorization is obtained, the QMA must do the following: (A) Document in the resident record symptoms indicating the need for the medication and time the symptoms occurred. (B) Document in the resident record that the facility's licensed nurse was contacted, symptoms were described, and permission was granted to administer the medication, including the time of contact. (C) Obtain permission to administer the medication each time the symptoms occur in the resident. (D) Ensure that the resident 's record is cosigned by the licensed nurse who gave permission by the end of the nurse's shift, or if the nurse was on call, by the end of the nurse's next tour of duty.</p> <p>On 4/9/25 at 12:14 P.M., the DON provided a current QMA job description, dated 3/23/17, that indicated Essential Duties and Responsibilities: .Administers and documents medications given by following specifically written physician orders including oral, topical, and suppository medications, as well as eye and ear drops . Maintains compliance to all personnel policies, established community policies and procedures, and Federal and State regulations and standards .</p> <p>3.1-35(g)(2)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48147</p> <p>Based on observation, interview, and record review, the facility failed to ensure residents dependent on staff for ADLs (activities of daily living) were showered and hair was shampooed for 9 of 10 residents reviewed for ADL care. (Resident P, Resident S, Resident G, Resident D, Resident B, Resident N, Resident F, Resident L, and Resident U)</p> <p>Findings include:</p> <p>1. During an interview on 4/4/25 at 9:03 A.M., Resident P indicated that she only got a shower once a week most weeks. She preferred a shower because staff didn't wash her hair when they gave her a bed bath. She indicated that she was told they were short staffed and sometimes didn't have time to get her up for a shower. She indicated that there was no one in the facility to cut her hair and that her family tried to fill that role. At that time, Resident P's hair was observed to be oily.</p> <p>On 4/7/25 at 12:35 P.M., Resident P's clinical record was reviewed. Diagnoses included, but were not limited to, cerebral palsy, diabetes mellitus, and major depressive disorder.</p> <p>The most current Quarterly Minimum Data Set (MDS) Assessment, dated 1/25/25, indicated Resident P was cognitively intact and was dependent on staff (staff does all of the effort) for bathing and toileting.</p> <p>The most current care plan conference was completed on 10/31/24. Care plans were reviewed and updated at that time.</p> <p>A current preferences care plan, initiated 2/12/21, indicated Resident P preferred showers twice weekly in the morning.</p> <p>A Point of Care (a charting system for CNAs) Tasks Response Form for showers indicated Resident P preferred showers on Tuesday and Friday day shift. Showers for the past 30 days were reviewed. Showers were not received on the following dates:</p> <p>3/11/25</p> <p>3/21/25</p> <p>2. On 4/3/25 at 11:32 A.M., Resident S was observed sleeping in her wheelchair in the hallway. Her hair was observed to be disheveled and unbrushed. She was noted to smell like urine.</p> <p>On 4/4/25 at 12:40 P.M., Resident S's clinical record was reviewed. Diagnoses included, but were not limited to, dementia, repeated falls, and major depressive disorder.</p> <p>The most current Quarterly Minimum Data Set (MDS) Assessment, dated 2/20/25, indicated that Resident S had severe cognitive impairment and required substantial to maximal assistance from staff (staff does more than half of the effort) for bathing and toileting.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Aperion Care Lincoln		STREET ADDRESS, CITY, STATE, ZIP CODE 1236 Lincoln Ave Evansville, IN 47714	
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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The most current care plan conference was completed on 11/14/24. Care plans were reviewed and updated at that time.</p> <p>A current preferences care plan, initiated 6/16/21, indicated Resident S preferred showers twice a week.</p> <p>An ADL care plan, initiated 5/29/24, indicated the resident needed substantial to maximal assistance with showers, and if the resident resisted care, to return five to ten minutes later and try again.</p> <p>A self care deficit care plan, initiated 6/16/21, indicated to staff to perform hair care daily and upon rising from nap.</p> <p>A Point of Care Tasks Response Form for showers indicated Resident P preferred showers on Tuesday and Friday evenings. Showers for the past 30 days were reviewed. Showers were not received on the following dates:</p> <p>3/11/25</p> <p>3/14/25</p> <p>3/18/25</p> <p>3/21/25 received a bed bath without shampoo</p> <p>3/25/25</p> <p>3/28/25</p> <p>3. During an interview on 4/3/25 at 11:44 A.M., Resident G indicated she was the last person to get up in the morning and she didn't want to be the last person to get up. She indicated that she only got bed baths and they never washed her hair during the bed bath. She indicated that she had just gotten a bed bath and her hair was not washed. At that time, Resident G's hair was observed to be in a braid, dry, and disheveled.</p> <p>On 4/7/25 at 11:16 A.M., Resident G's clinical record was reviewed. Diagnoses included, but were not limited to, dementia, cerebral infarction, and depression.</p> <p>The most current Significant Change Minimum Data Set (MDS) Assessment, dated 3/17/25, indicated that Resident G had mild cognitive impairment and was dependent on staff (staff does all of the effort) for bathing and toileting.</p> <p>The most current care plan conference was completed on 2/27/25. Care plans were reviewed and updated at that time.</p> <p>A current preferences care plan, initiated 2/23/24, indicated Resident G preferred showers twice a week in the morning.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A Point of Care Tasks Response Form for showers indicated Resident P preferred showers on Tuesday and Thursday day shift. Showers for the past 30 days were reviewed. Showers were not received on the following dates:</p> <p>3/11/25</p> <p>3/13/25</p> <p>3/18/25 received a bed bath without shampoo</p> <p>3/20/25 received a bed bath without shampoo</p> <p>3/25/25</p> <p>3/27/25</p> <p>4. During an interview on 4/3/25 at 2:29 P.M., Resident D's family member indicated that since there was no one in the facility to cut the residents hair, he cut Resident D's hair. A few weeks ago, Resident D had sustained a fall that required staples to his head. Five days after the resident received the staples, the family member visited Resident D and attempted to cut his hair. He indicated that there was still blood behind his ears like he hadn't been showered well since the incident.</p> <p>On 4/7/25 at 2:40 P.M., Resident D's clinical record was reviewed. Diagnoses included, but were not limited to, wedge compression fracture of unspecified lumbar vertebra and unsteadiness on feet.</p> <p>The most current Quarterly Minimum Data Set (MDS) Assessment, dated 2/18/25, indicated Resident D had severe cognitive impairment, required substantial to maximal assistance of staff (staff does more than half of the effort) for bathing and toileting, and had two or more falls without injury since the prior assessment.</p> <p>The most current care plan conference was completed on 11/7/24. Care plans were reviewed and updated at that time.</p> <p>A current preferences care plan, initiated 2/14/24, indicated Resident D preferred showers twice a week.</p> <p>An ADL care plan, initiated 1/27/25, indicated the resident needed substantial to maximal assistance with showers, and if the resident resisted care, to return five to ten minutes later and try again.</p> <p>A Point of Care Tasks Response Form for showers indicated Resident P preferred showers on Monday and Thursday day shift. Showers for the past 30 days were reviewed. Showers were not received on the following dates:</p> <p>3/10/25 received a bed bath without shampoo</p> <p>3/13/25</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>3/20/25 received a bed bath with shampoo</p> <p>3/24/25</p> <p>3/27/25 received a bed bath with shampoo</p> <p>3/31/25</p> <p>On 4/8/25 at 10:14 A.M., CNA 23 indicated that there was never enough staff to get everything done.</p> <p>48057</p> <p>5. On 4/7/25 at 9:24 A.M., Resident B's clinical record was reviewed. Diagnosis included, but was not limited to, hypertensive encephalopathy.</p> <p>The most recent Annual Minimum Data Set assessment, dated 1/3/25, indicated Resident B was moderately cognitively intact, required partial assistance from staff (staff do half of the work) for toileting and transfers, and required substantial assistance for bathing (staff do more than half of the work).</p> <p>Resident B's Activities of Daily Living (ADL) tasks indicated bathing was preferred on Tuesdays and Fridays.</p> <p>During the last 30 days, Resident B did not receive showers during the following dates:</p> <p>3/11/25</p> <p>3/21/25</p> <p>3/25/25</p> <p>6. On 4/4/25 at 12:48 P.M., Resident N's clinical record was reviewed. Diagnosis included, but was not limited to, diabetes mellitus with diabetic polyneuropathy.</p> <p>The most recent Quarterly MDS assessment, dated 3/20/25, indicated Resident N was cognitively intact, required substantial assistance from staff (staff do more than half of the work) for bathing and transfers, was at risk for pressure ulcers, and had no pressure ulcers.</p> <p>Resident N's Activities of Daily Living (ADL) tasks indicated bathing was received on Monday and Thursday.</p> <p>During the last 30 days, Resident N did not receive showers during the following dates:</p> <p>3/17/25</p> <p>3/24/25</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>3/27/25</p> <p>3/31/25</p> <p>4/3/25</p> <p>7. On 4/7/25 at 11:57 A.M., Resident F's clinical record was reviewed. Diagnosis included, but was not limited to, hypertension.</p> <p>The most recent Quarterly MDS assessment, dated 2/17/25, indicated Resident F was cognitively intact, required partial assistance (staff do half of the work) for showers and substantial assistance for transfers to the shower.</p> <p>Resident F's Activities of Daily Living (ADL) tasks indicated bathing was preferred on Monday and Thursday.</p> <p>During the last 30 days, Resident F did not receive showers during the following dates:</p> <p>3/13/25</p> <p>3/17/25</p> <p>3/24/25</p> <p>3/27/25</p> <p>4/7/25</p> <p>8. During an observation on 4/4/25 at 8:59 A.M., Resident L's hair appeared unkempt and her fingernails were long and yellow tinged. Resident L indicated she had not had her hair washed since admission.</p> <p>On 4/7/25 at 8:55 A.M., Resident L's clinical record was reviewed. Resident L was admitted on [DATE]. Diagnosis included, but was not limited to, malignant neoplasm.</p> <p>The most recent Admission Minimum Data Set (MDS) assessment, dated 3/25/25, indicated Resident L was cognitively intact and required partial assistance (staff do half of the work) for toileting and bathing.</p> <p>Resident L's Activities of Daily Living (ADL) tasks indicated Resident L had zero days documented for shampoo during bathing since admission.</p> <p>9. On 4/7/25 at 12:29 P.M., Resident U's clinical record was reviewed. Resident U was admitted on [DATE]. Diagnosis included, but was not limited to, type 2 diabetes mellitus.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The most recent Admission Minimum Data Set (MDS) assessment, dated 3/24/25, indicated Resident U was moderately cognitively intact, required substantial assistance for bathing (staff do more than half of the work), was dependent on staff for toileting (staff do all of the work), and required partial assistance for transfers (staff do at least half of the work).</p> <p>Resident U's Activities of Daily Living (ADL) tasks indicated bathing was received on Monday and Thursday.</p> <p>During the last 30 days, Resident U did not receive showers during the following dates:</p> <p>3/24/25</p> <p>3/27/25</p> <p>3/31/25</p> <p>4/3/25</p> <p>During an interview on 4/9/25 at 10:14 A.M., the Director of Nursing (DON) indicated the interdisciplinary team was aware ADL's such as showers not being given were an ongoing concern and indicated there was not a specific person in charge of making sure showers were given, and that ADL's not being performed was an ongoing issue during the last year.</p> <p>On 4/9/25 at 12:14 P.M., the DON provided a policy titled Bathing Shower and Tub Bath, revised 1/18, that indicated A shower, tub bath or bed/sponge bath will be offered according to resident's preferences two times per week or according to the resident's preferred frequency and as needed or requested.</p> <p>This citation relates to Complaint IN00456840 and Complaint IN00449780.</p> <p>3.1-38(a)(3)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48057</p> <p>Based on interview, record review, and observation, the facility failed to identify the potential for the development of pressure ulcers, perform routine skin checks, and follow the plan of care to promote wound healing for 2 of 2 residents reviewed for facility acquired heel wounds. (Resident F, Resident F)</p> <p>Findings include:</p> <p>1. During an interview on 4/4/25 at 2:29 P.M., Resident N was observed to have a wound vac (a medical device that uses negative pressure to promote wound healing) on his right heel. Resident N indicated it started out as a blister and developed larger requiring surgical debridement and a skin graft. Resident N indicated the wound resulted in him staying in the facility longer than anticipated.</p> <p>On 4/4/25 at 12:48 P.M., Resident N's clinical record was reviewed. Resident N was admitted on [DATE] for therapy following a recent fracture surgery. Diagnosis included, but was not limited to, diabetes mellitus with diabetic polyneuropathy.</p> <p>An Admission Minimum Data Set (MDS) assessment, dated 12/29/24, indicated Resident N was cognitively intact, required partial assistance (staff do at least half of the work) to roll left to right, required substantial assistance (staff do more than half of the work) for bathing, transfers, putting on and taking off footwear, and performing personal hygiene, and was at risk for pressure ulcers but had no pressure ulcers.</p> <p>The clinical record lacked a comprehensive care plan related to Resident N's risk for pressure ulcer development.</p> <p>The clinical record lacked weekly skin observations from 11/29/24 to 1/8/25.</p> <p>A weekly skin observation, dated 1/8/25 at 2:49 P.M., indicated Resident N had a skin concern of the pressure injury to the right heel and skin concerns observed are not new.</p> <p>A skin wound report, dated 1/8/25, indicated Resident N had developed a new in-house acquired pressure injury to the right heel. Measurements of the wound were: length 6 cm (centimeters), width 8 cm, and depth 0.2 cm, and staging was left blank.</p> <p>A medication order was started on 1/9/25 for ascorbic acid 500 mg (milligrams) tablet give one tablet by mouth one time a day for wound healing, and was discontinued on 1/23/25.</p> <p>A treatment order was started on 1/9/25 that indicated to cleanse area with wound cleanser and pat dry, skin prep peri-wound area and allow to completely dry, cover wound bed with honey alginate (a type of wound dressing that combines the properties of honey and calcium alginate, works by absorbing wound fluid, forming a gel that helps maintain a moist environment conducive to healing and potentially supporting the removal of necrotic tissue), cover with ABD (abdominal) pad and wrap with Kerlix (gauze wrap) every day shift for pressure injury to right heel, and was discontinued on 1/23/25.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A wound evaluation, dated 1/13/25, indicated Resident N's right heel wound was an unstageable deep tissue pressure injury. The evaluation indicated to float the residents heels.</p> <p>A nursing progress note on 1/18/25 at 9:09 P.M., indicated Resident N was sent to the hospital for coffee ground emesis.</p> <p>2. During an interview on 4/7/25 at 10:59 A.M., Resident F indicated that he was admitted for therapy from a wreck but stayed at the facility due to the wound on his foot, and he believed was not healed yet due to the dressing not being changed.</p> <p>On 4/7/25 at 11:57 A.M., Resident F's clinical record was reviewed. Resident F was admitted on [DATE]. Diagnosis included, but was not limited to, hypertension.</p> <p>An Admission MDS assessment, dated 11/26/24, indicated Resident F was cognitively intact, was dependent (staff do all of the work) for putting on and taking off footwear, required substantial assistance from staff (staff do more than half of the work) for bathing and transfers, required partial assistance (staff do at least half of the work) to roll left to right, was at risk for pressure ulcers, and had no unhealed pressure ulcers.</p> <p>A skin wound report, dated 12/18/24, indicated Resident F had developed a new in-house acquired pressure injury to the left heel. Measurements of the wound were: length 2.5 cm (centimeters), width 7 cm, and was a deep tissue injury.</p> <p>A care plan was created on 12/19/24 and indicated I have a pressure injury to my left heel related to immobility.</p> <p>The care plan lacked at risk for developing skin breakdown monitoring prior to pressure ulcer development.</p> <p>A treatment order was started on 1/3/25 that indicated cleanse area (left heel) with wound cleanser, gently pat dry, apply skin prep peri-wound area and allow to completely dry, apply honey impregnated calcium alginate to wound bed and cover with ABD (abdominal) pad and wrap with Kerlix (gauze wrap) every day shift for pressure injury to left heel, and was discontinued on 1/13/25.</p> <p>The following dates in the electronic treatment administration record (TAR) indicated Resident F's wound treatment was not changed and was not refused:</p> <p>1/4/25</p> <p>1/13/25</p> <p>A physician progress note, dated 1/3/25, indicated Resident F had been working with therapy and was using the parallel bar, but now had a heel ulcer and unable to walk as much.</p> <p>A treatment order was started on 1/21/25 that indicated cleanse area (left heel) with wound cleanser, gently pat dry, apply skin prep peri-wound area and allow to completely dry, apply honey alginate to wound bed, cover with ABD pad, wrap with Kerlix and secure with medical tape, every day shift for pressure injury to left heel, and was discontinued on 1/28/25.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The following dates in the electronic treatment administration record (TAR) indicated Resident F's wound treatment was not changed and was not refused:</p> <p>1/23/25</p> <p>1/25/25</p> <p>A treatment order was started on 1/29/25 that indicated cleanse area (left heel) with wound cleanser, gently pat dry. Apply skin prep peri- wound area and allow to completely dry. Paint area with betadine and allow to dry, cover with ABD pad, wrap with Kerlix and secure with medical tape every day shift for pressure injury to left heel, and was discontinued on 2/24/25.</p> <p>The following dates in the electronic treatment administration record (TAR) indicated Resident F's wound treatment was not changed and was not refused:</p> <p>2/7/25</p> <p>2/8/25</p> <p>2/14/25</p> <p>2/21/25</p> <p>The most recent Quarterly MDS assessment, dated 2/17/25, indicated Resident F was cognitively intact, required partial assistance (staff do half of the work) for showers and putting on and taking off foot wear, and substantial assistance for transfers to the shower, was at risk for pressure ulcers, and had an unstageable pressure ulcer.</p> <p>A treatment order was started on 2/25/25 that indicated cleanse area (left heel) with wound cleanser, gently pat dry, apply skin prep peri-wound area and allow to completely dry, cut to fit honey alginate and place in wound bed, cover with ABD pad, wrap with Kerlix and secure with medical tape, and was discontinued on 3/17/25.</p> <p>The following dates in the electronic treatment administration record (TAR) indicated Resident F's wound treatment was not changed and was not refused:</p> <p>3/4/25</p> <p>3/9/25</p> <p>A medication order was started on 3/12/25 that indicated cephalexin (antibiotic) capsule 500 MG (milligrams) give one capsule by mouth three times a day for (foot wound) infection for 10 days, and was discontinued on 3/22/25.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A treatment order was started on 3/18/25 that indicated cleanse area (left heel) with wound cleanser, gently pat dry, apply skin prep peri- wound area and allow to completely dry, apply layer of Manuka Honey to wound bed, place calcium alginate over wound bed, cover with Hydra Lock dressing, cover with ABD pad, wrap with Kerlix and secure with medical tape, every day shift for pressure injury to left heel, and was discontinued on 3/31/25.</p> <p>The following dates in the electronic treatment administration record (TAR) indicated Resident F's wound treatment was not changed and was not refused:</p> <p>3/21/25</p> <p>A treatment order was started on 3/31/25 that indicated enhanced barrier precautions: staff to wear gown and gloves during all high contact resident care activities every shift for surgical site to right heel.</p> <p>The most recent wound measurements, dated 3/31/25, indicated Resident F's left heel wound measured 2 cm length, 2 cm width, and 0.3 cm depth.</p> <p>A treatment order was started on 4/1/25 that indicated cleanse area (left heel) with wound cleanser, gently pat dry, skin prep peri-wound and allow to completely dry, cover wound bed with HydraLock (an absorbent dressing) dressing, cover with ABD (abdominal) pad, wrap with Kerlix (gauze bandage), and secure with medical tape every day shift for pressure injury to left heel.</p> <p>The following dates in the electronic treatment administration record (TAR) indicated Resident F's wound treatment was not changed or refused:</p> <p>4/1/25</p> <p>4/8/25</p> <p>During an interview on 4/8/25 at 1:23 P.M. the Director of Nursing (DON) indicated staff should be following physician's orders as written.</p> <p>During an observation on 4/9/25 at 11:40 A.M., Resident F was observed with a dressing, dated 4/7, around his left foot.</p> <p>On 4/9/25 at 12:14 P.M., the DON provided a policy titled Pressure Ulcer Prevention, revised 1/15/18, indicated The purpose: to prevent pressure sores/ pressure injury. Maintain clean/dry skin inspect the skin several times daily. Use positioning devices to reduce pressure (provide) supplements as ordered.</p> <p>This citation relates to complaint IN00456840.</p> <p>3.1-40(a)(1)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>48147</p> <p>Based on observation, interview, and record review, the facility failed to follow fall protocol, revise care plans, and follow interventions to reduce the risk of falls for 2 of 2 residents reviewed for falls. (Resident D and Resident S)</p> <p>Findings include:</p> <p>1. During a confidential interview during the survey, it was indicated that Resident D had fallen a lot while attempting to self toilet because when he pushed his call light no one came to help him to the bathroom.</p> <p>On 4/4/25 at 1:26 P.M., Resident D was observed sitting by himself in his wheelchair in his room eating. The call light was wrapped around the bed rail and was not clipped to or within reach of the resident. There was not a dycem in his wheelchair. The resident was wearing socks without nonskid bottoms. Non skid strips were not observed anywhere in the resident's room.</p> <p>On 4/7/25 at 2:40 P.M., Resident D's clinical record was reviewed. Diagnoses included, but were not limited to, dementia, epileptic seizures, wedge compression fracture of unspecified lumbar vertebra, repeated falls, unsteadiness on feet, and weakness.</p> <p>The most recent Quarterly Minimum Data Set (MDS) Assessment, dated 2/18/25, indicated Resident D had severe cognitive impairment, required substantial to maximal assistance of staff (staff does more than half of the effort) for toileting, bathing, and transferring, and had 2 or more falls without injury since the prior assessment on 1/6/25.</p> <p>The last care plan conference was completed on 11/7/24. Care plans were reviewed and updated at that time.</p> <p>A current high fall risk care plan, initiated 2/17/24, included the following interventions:</p> <p>Anticipate and meet residents needs, dated 2/17/24</p> <p>Be sure residents call light is within reach and encourage resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance, 2/17/24</p> <p>Ensure that resident is wearing appropriate footwear when ambulating or mobilizing in wheel chair, dated 2/17/24</p> <p>Follow facility fall protocol if fall occurs, dated 2/17/24</p> <p>Notify family and physician of all falls, dated 2/17/24</p> <p>Physical Therapy (PT) and Occupational Therapy (OT) evaluations and treatments as ordered and as needed (PRN), dated 2/17/24</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Aperion Care Lincoln		STREET ADDRESS, CITY, STATE, ZIP CODE 1236 Lincoln Ave Evansville, IN 47714	
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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The resident needs activities that minimize the potential for falls while providing diversion and distraction, dated 2/17/24</p> <p>Resident placed on night shift get up list as he is an early riser, dated 3/5/24</p> <p>Call light clip placed on call light and staff educated to clip call light to resident clothes or chair so resident can easily find call light, dated 3/24/24</p> <p>Ensure resident is toileted prior to resident going to bed, dated 4/21/24</p> <p>Anti-rollbacks to wheelchair, dated 6/8/24</p> <p>Anti-tippers to wheelchair, dated 6/11/24</p> <p>Call, Don't Fall signs in room and in bathroom as reminder for him to call before he attempts to get up unassisted, dated 6/19/24</p> <p>Dycem to wheelchair, dated 6/23/24</p> <p>Fall mat to be placed at bedside when he is in bed, dated 6/25/24</p> <p>Reach out to Medical Doctor (MD) for a sleep aide, dated 6/29/24</p> <p>Offer sleep aide, dated 6/29/24</p> <p>Staff to offer resident assistance to recliner to rest after lunch, dated 7/5/24</p> <p>Therapy to adjust anti-rollbacks on resident's wheelchair, dated 7/15/24</p> <p>Resident is not to be left in his room in his wheelchair unattended, dated 8/6/24</p> <p>Re-educate nursing staff that resident is not to be left alone in room alone in wheelchair, dated 9/9/24</p> <p>Ensure resident is toileted before and after each meal, dated 11/13/24</p> <p>Reinforce to nursing staff that resident is not to be left alone in room while in wheelchair, dated 11/27/24</p> <p>Keep personal belongings within reach of resident, dated 1/6/25</p> <p>Staff to encourage resident to sleep in his bed at night instead of recliner, dated 1/23/25</p> <p>Call, Don't Fall sign placed in public restroom next to pantry on first floor, dated 2/3/25</p> <p>Bolster mattress placed on bed to prevent resident from rolling out of bed while sleeping, dated 3/10/25</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The clinical record indicated Resident D fell 23 times in the past year.</p> <p>Fall 1</p> <p>On 5/22/24 at 5:30 P.M., Resident D had an unwitnessed fall while attempting to self transfer between the wheelchair and bed. He was found sitting on the floor in his room in front of his wheelchair and bed.</p> <p>The clinical record lacked an Interdisciplinary Team (IDT) note about that fall.</p> <p>The care plan was not updated with a new intervention.</p> <p>A fall risk assessment, dated 5/22/24, indicated Resident D was at high risk for falls.</p> <p>Fall 2</p> <p>On 5/23/24 at 2:17 P.M., Resident D had an unwitnessed fall while attempting to self toilet. A CNA heard a noise coming from the resident's room and went to check on the resident. The resident was sitting in his wheelchair in the bathroom next to the toilet. The resident indicated that he fell down and put himself back into his wheelchair. The nurse assessed the resident.</p> <p>The physician and responsible party were not notified about that fall.</p> <p>The clinical record lacked an IDT note about that fall.</p> <p>The care plan was not updated with a new intervention.</p> <p>A fall risk assessment was not completed.</p> <p>Fall 3</p> <p>On 6/8/24 at 8:25 A.M., Resident D had an unwitnessed fall while attempting to close the door in his room.</p> <p>The IDT reviewed that fall on 6/11/24. Anti-rollbacks to wheelchair was added to the care plan.</p> <p>A fall risk assessment, dated 6/8/24, indicated Resident D was at high risk for falls.</p> <p>Fall 4</p> <p>On 6/11/24 at 8:09 P.M., Resident D had an unwitnessed fall while attempting to self toilet. He was found lying on his bathroom floor in front of his wheelchair.</p> <p>The IDT reviewed that fall on 6/11/24. Anti-tippers to wheelchair was added to the care plan.</p> <p>A fall risk assessment was not completed.</p> <p>Fall 5</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 6/12/24 at 1:42 A.M., Resident D had an unwitnessed fall while attempting to self toilet. He was found sitting on the bathroom floor.</p> <p>The physician and responsible party were not notified about that fall.</p> <p>The clinical record lacked an IDT note about that fall.</p> <p>The care plan was not updated with a new intervention.</p> <p>A fall risk assessment was not completed.</p> <p>Fall 6</p> <p>On 6/19/24 at 10:35 A.M., Resident D had an unwitnessed fall while attempting to self toilet. A CNA responded to a call light in the resident's room and found the resident lying on the floor on his right side with his feet towards the door of the bathroom. The resident complained of bilateral hip pain. The physician was notified, and an order was received for an x-ray of the hip and pelvis. The results of that x-ray were negative.</p> <p>The IDT reviewed that fall on 6/21/24. Call, Don't Fall signs in room and in bathroom as reminder for him to call before he attempts to get up unassisted was added to the care plan.</p> <p>A fall risk assessment, dated 6/19/24, indicated Resident D was at high risk for falls.</p> <p>Fall 7</p> <p>On 6/23/24 at 8:35 A.M., Resident D had an unwitnessed fall while in his room. The resident was found on his knees on the floor in front of his bed.</p> <p>The clinical record lacked an IDT note about that fall.</p> <p>The care plan was not updated with a new intervention.</p> <p>A fall risk assessment, dated 6/23/24, indicated Resident D was at high risk for falls.</p> <p>Fall 8</p> <p>On 6/23/24 at 12:25 P.M., Resident D had an unwitnessed fall while in his room. A visitor alerted the nurse that the resident was lying on the floor in his room. The resident was noted to have a two inch by one inch bruised area on the top right side of his head. The physician was notified, and an order was received to send the resident to the hospital for evaluation.</p> <p>The resident returned to the facility from the hospital at 7:05 P.M. A computed tomography (CT) scan (a medical imaging technique used to obtain detailed internal images of the body) indicated there were no new injuries related to recent falls; however, the resident's chronic back fracture had gotten worse.</p> <p>The clinical record lacked an IDT note about that fall.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Dycem to wheelchair was added to the care plan on 6/23/24.</p> <p>A fall risk assessment, dated 6/23/24, indicated Resident D was at high risk for falls.</p> <p>Fall 9</p> <p>On 6/25/24 at 10:16 A.M., Resident D had an unwitnessed fall in his room. The resident was found lying on the floor between his bed and wheelchair.</p> <p>The IDT reviewed that fall on 6/26/24. Fall mat to be placed at bedside when he is in bed was added to the care plan.</p> <p>A fall risk assessment, dated 6/25/24, indicated Resident D was at high risk for falls.</p> <p>Fall 10</p> <p>On 6/29/24 at 10:34 P.M., Resident D had an unwitnessed fall while in his room. The resident was found on the floor next to his bed. He complained of right knee pain. The physician was notified, and an order was received to send the resident to the hospital for evaluation.</p> <p>The resident returned to the facility from the hospital on 6/30/24 at 5:15 A.M. with a new order for bacitracin ointment to the abrasion on his right knee twice a day for seven days. No other injuries were noted.</p> <p>The IDT reviewed that fall on 7/1/24. Reach out to Medical Doctor (MD) for a sleep aide and Offer sleep aide were added to the care plan.</p> <p>A new order to give melatonin (a supplement to help with insomnia) 5 milligrams (mg) by mouth every 24 hours as needed for trouble sleeping was received on 7/3/24.</p> <p>A fall risk assessment was not completed.</p> <p>Fall 11</p> <p>On 7/4/24 at 3:30 P.M., Resident D had an unwitnessed fall while attempting to put himself to bed. The resident was found on the floor in front of his bed.</p> <p>The clinical record lacked an IDT note about that fall.</p> <p>Staff to offer resident assistance to recliner to rest after lunch was added to the care plan.</p> <p>A fall risk assessment, dated 7/4/24, indicated Resident D was at high risk for falls.</p> <p>Fall 12</p> <p>On 7/15/24 at 2:30 P.M., Resident D had a witnessed fall while trying to get up using the rail in the hallway. The wheelchair moved and the resident fell and hit the back of his head.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The clinical record lacked an IDT note about that fall.</p> <p>Therapy to adjust anti-rollbacks on resident's wheelchair was added to the care plan on 7/15/24.</p> <p>A fall risk assessment, dated 7/15/24, indicated Resident D was at high risk for falls.</p> <p>Fall 13</p> <p>On 8/6/24 at 11:17 A.M., Resident D had an unwitnessed fall while attempting to pick something up off the floor. The resident was found lying on the floor in the doorway of his room.</p> <p>The IDT reviewed that fall on 8/7/24. Resident is not to be left in his room in his wheelchair unattended was added to the care plan.</p> <p>A fall risk assessment, dated 8/6/24, indicated Resident D was at high risk for falls.</p> <p>Fall 14</p> <p>On 8/14/24 at 2:00 A.M., Resident D had an unwitnessed fall in his room. He was found lying on his fall mat.</p> <p>The clinical record lacked an IDT note about that fall.</p> <p>The care plan was not updated with a new intervention.</p> <p>A fall risk assessment, dated 8/14/24, indicated Resident D was at high risk for falls.</p> <p>Fall 15</p> <p>On 8/19/24 at 2:09 P.M., Resident D had an unwitnessed fall while attempting to self toilet. A CNA responded to the resident's call light and found him sitting against the wall next to the toilet.</p> <p>The clinical record lacked an IDT note about that fall.</p> <p>The care plan was not updated with a new intervention.</p> <p>A fall risk assessment, dated 8/21/24, indicated Resident D was at high risk for falls.</p> <p>Fall 16</p> <p>On 11/13/24 at 11:15 A.M., Resident D had an unwitnessed fall while attempting to self toilet. A CNA responded to an emergency call light in the hallway bathroom and found the resident lying on his back on the floor next to the toilet with his wheelchair by his side. The resident was noted to have a bruise on the left side of his forehead.</p> <p>The IDT reviewed that fall on 11/25/24. Ensure resident is toileted before and after each meal was added to the care plan.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A fall risk assessment, dated 11/24/25, indicated Resident D was at high risk for falls.</p> <p>Fall 17</p> <p>On 11/27/24 at 3:12 P.M., Resident D had an unwitnessed fall while attempting to self toilet. The resident was found sitting on the floor between the toilet and the sink.</p> <p>The IDT reviewed that fall on 12/3/24. Reinforce to nursing staff that resident is not to be left alone in room while in wheelchair was added to the care plan.</p> <p>A fall risk assessment, dated 11/27/24, indicated Resident D was at high risk for falls.</p> <p>Fall 18</p> <p>On 12/27/24 at 4:30 P.M., Resident D had an unwitnessed fall while attempting to throw an item away. The resident was found sitting upright on the floor next to his recliner.</p> <p>The IDT reviewed that fall on 12/31/24. The new intervention determined at that meeting was to add non skid strips in front of the resident's recliner.</p> <p>The care plan was not updated with a new intervention.</p> <p>A fall risk assessment, dated 12/27/24, indicated Resident D was at high risk for falls.</p> <p>Fall 19</p> <p>On 1/6/25 at 7:00 A.M., Resident D had an unwitnessed fall while attempting to walk to get a tissue box that was in the corner of his room. The resident was found lying on the floor on his back next to his wheelchair. The resident complained of pain to his right abdomen. The physician was notified.</p> <p>On 1/7/25 at 3:09 P.M., an order was received for an x-ray of the thoracic spine right side rib due to pain after the fall.</p> <p>The x-ray was completed on 1/8/25. Results were negative and there were no new orders.</p> <p>The IDT reviewed that fall on 1/9/25. Keep personal belongings within reach of resident was added to the care plan.</p> <p>A fall risk assessment, dated 1/9/25, indicated Resident D was at high risk for falls.</p> <p>Fall 20</p> <p>On 1/23/25 at 4:14 A.M., Resident D had an unwitnessed fall while attempting to self transfer from his recliner to his wheelchair. The resident was found lying on his back on the floor in front of his recliner.</p> <p>The IDT reviewed that fall on 1/23/25. Staff to encourage resident to sleep in his bed at night instead of recliner was added to the care plan.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A fall risk assessment, dated 1/23/25, indicated Resident D was at high risk for falls.</p> <p>Fall 21</p> <p>On 2/3/25 at 6:00 P.M., Resident D had an unwitnessed fall while attempting to self toilet. A CNA responded to a call light in the hallway bathroom. The resident was found lying on the ground next to the toilet.</p> <p>The IDT reviewed that fall on 2/5/25. Call, Don't Fall sign placed in public restroom next to pantry on first floor was added to the care plan.</p> <p>A fall risk assessment, dated 2/3/25, indicated Resident D was at high risk for falls.</p> <p>Fall 22</p> <p>On 3/10/25 at 5:15 A.M., Resident D had an unwitnessed fall in his room. The resident was found on the floor between his bed and the bathroom floor. The resident was noted to have bleeding from a laceration on the back of his head and there was a large amount of blood on the floor. The physician was notified, and an order was received to send the resident to the hospital for treatment and evaluation.</p> <p>The resident returned back to the facility from the hospital on 3/10/25 at 10:06 A.M. with eight staples to the back of his head on the left side.</p> <p>The IDT reviewed that fall on 3/11/25. Bolster mattress placed on bed to prevent resident from rolling out of bed while sleeping was added to the care plan.</p> <p>A fall risk assessment, dated 3/10/25, indicated Resident D was at high risk for falls.</p> <p>Fall 23</p> <p>A 72-hour charting note, dated 4/3/25 at 6:53 P.M., indicated Resident D was assessed for a fall. The note did not indicate when, where, or how the fall took place.</p> <p>The clinical record lacked documentation regarding the fall that took place on 4/3/25.</p> <p>The clinical record lacked documentation to indicate the physician and responsible party were notified of that fall.</p> <p>The clinical record lacked an IDT note about that fall.</p> <p>The care plan was not updated with a new intervention.</p> <p>A fall risk assessment was not completed.</p> <p>A nursing progress note, dated 4/4/25 at 9:17 A.M., indicated that the resident was not acting like himself. He was unable to stand up and complained of pain to his left hip, left arm, left shoulder, and left flank. The physician was notified.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A nursing progress note, dated 4/4/25 at 10:47 A.M., indicated that the physician was in the facility and assessed the resident. Orders for bloodwork and an x-ray of the left shoulder and left hip were received.</p> <p>A nursing progress note, dated 4/4/25 at 2:13 P.M., indicated the resident was hallucinating.</p> <p>A nursing progress note, dated 4/4/25 at 3:10 P.M., indicated a new order was received to send the resident to the hospital for treatment and evaluation.</p> <p>A nursing progress note, dated 4/4/25 at 3:41 P.M., indicated ambulance staff picked up the resident from the facility and transported him to the hospital for the possibility of trauma from a fall.</p> <p>Hospital admission paperwork, dated 4/4/25, indicated the CT scan was negative for acute injury or fracture, urinalysis was negative for UTI, and blood workup was unremarkable. The resident was admitted to the hospital for evaluation of acute encephalopathy.</p> <p>A hospital neurology note, dated 4/7/25, indicated that the resident was on anticonvulsant medication for seizures prior to his hospitalization and because there were no other remarkable findings, a new anticonvulsant medication would be trialed to attempt to address the mental and ADL decline.</p> <p>2. On 4/4/25 at 12:40 P.M., Resident S's clinical record was reviewed. Diagnoses included, but were not limited to, dementia, muscle weakness, and repeated falls.</p> <p>The most recent Annual Minimum Data Set (MDS) Assessment, dated 2/5/25, indicated Resident S had severe cognitive impairment, required partial to moderate assistance of staff (staff does less than half of the effort) for transferring, required substantial to maximal assistance of staff (staff does more than half of the effort) for toileting and bathing, and had two or more falls since the prior assessment.</p> <p>The last care plan conference was completed on 11/14/24. Care plans were reviewed and updated.</p> <p>A current increased risk for falls care plan, initiated 6/16/21, included the following interventions:</p> <p>Anticipate and meet residents needs, dated 6/16/21</p> <p>Be sure residents call light is visible and within reach. The resident needs prompt response to all requests for assistance, dated 6/16/21</p> <p>Follow facility fall protocol if fall occurs, dated 6/16/21</p> <p>Notify family and physician of all falls, dated 6/16/21</p> <p>Nursing to check on resident every hour throughout the night, dated 11/22/21</p> <p>Place Call, Don't Fall sign within view of resident's recliner, dated 3/4/22</p> <p>Place a call for assistance with showers sign in bathroom, dated 3/15/22</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Resident is always cleaning and tidying up her room. Call, don't fall sign replaced and resident encouraged to leave it up as a reminder, dated 3/16/22</p> <p>Move resident to room closer to nurses station for closer observation, dated 4/6/22</p> <p>Staff to offer toileting/shower/hygiene needs an hour prior to dinner, dated 4/10/22</p> <p>Physical Therapy (PT) and Occupational Therapy (OT) to assess seating positioning in recliner; replace recliner, dated 4/15/22</p> <p>Place STOP sign in shower entry, dated 4/24/22</p> <p>Offer/assist with toileting prior to lunch, dated 4/24/22</p> <p>Offer/encourage and assist resident with toileting needs prior to breakfast, dated 5/30/22</p> <p>Use a wheelchair to get resident monthly weights, dated 6/2/22</p> <p>OT to screen for transfers/positioning, dated 8/26/22</p> <p>Remove recliner from resident room and replace it with a stationary chair, dated 8/26/22</p> <p>Re-educate nursing staff to assist resident with toileting needs prior to lunch, dated 9/29/22</p> <p>If resident is ambulating outside of her room, ensure resident is wearing appropriate footwears. She prefers to be barefoot however, assist her with footwear prior to leaving her room, dated 12/4/22</p> <p>Staff to assist resident with toileting prior to her bedtime, dated 3/15/23</p> <p>Re-educate nursing staff to encourage and assist resident to put on proper footwears and keep it on at all times, dated 3/30/23</p> <p>Therapy to assess walker for safety, dated 4/14/23</p> <p>Staff to ensure walker is within reach at all times, dated 6/12/23</p> <p>Ensure slippers are within reach at all times, dated 6/20/23</p> <p>Staff to check in with resident approximately 30 minutes prior to dinner to see if she needs anything before her tray arrives, dated 9/15/23</p> <p>Urinalysis for recent falls and increased confusion, dated 10/14/23</p> <p>Ensure staff bathes resident in shower room for safety of resident and staff in case of an episode where staff has more room to ensure resident's safety, dated 3/2/24</p> <p>Staff to offer resident assistance with toileting when picking up room tray at lunch, dated 3/4/24</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Aperion Care Lincoln		STREET ADDRESS, CITY, STATE, ZIP CODE 1236 Lincoln Ave Evansville, IN 47714	
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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Resident referred to therapy for screen due to lower extremity weakness, dated 3/20/24</p> <p>Kitchen chair removed from resident room, 3/26/24</p> <p>Toilet rise to be placed on toilet, dated 4/29/24</p> <p>Psych med review per (name of mental health provider) Nurse Practitioner (NP), dated 6/28/24</p> <p>Bolsters placed on bed, dated 7/3/24</p> <p>Staff to encourage/assist resident with laying in bed with feet elevated rather than sit on the side leaning over the bed, dated 7/14/24</p> <p>Staff to offer opportunities for 1:1 activities throughout the day, dated 7/22/24</p> <p>Review information on past falls and attempt to determine cause of falls. Record possible root causes. Educate resident/family/caregivers/IDT as to causes, dated 8/12/24</p> <p>Remove non-skid strips from floor as these appear to be more of a hazard to her as she is always leaned over picking at them and pulling them up, putting her at an increased risk for falls, dated 8/28/24</p> <p>Re-educate nursing staff on offering assistance to resident with toileting and her safety checks, dated 8/29/24</p> <p>Therapy to screen/evaluate resident for safe self transfers, dated 11/27/24</p> <p>Therapy to trial assistive device to help assist with proper functioning, dated 12/4/24</p> <p>Environmental room check for furniture placement to better suit resident's needs, dated 12/4/24</p> <p>Therapy to fit for appropriate wheelchair, dated 1/13/25</p> <p>Ankle Brachial Index (ABI) (a test that measures blood pressure in your arms and ankles to check for peripheral artery disease) ordered to assess current status of vascular insufficiency to confirm or rule out any worsening disease processes that may possibly be causing increase in pain to BLE, dated 1/14/25</p> <p>Maintenance to assess status of TV and address issues if found, dated 1/21/25</p> <p>Notify MDS for Med Review for sleep aid, dated 1/23/25</p> <p>Staff to frequently ensure resident is wearing appropriate footwear, dated 1/25/25</p> <p>Bolster mattress to be placed on bed, dated 3/3/25</p> <p>The clinical record indicated Resident S fell 34 times in the past year.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Fall 1</p> <p>On 4/29/24 at 9:05 A.M., Resident S had an unwitnessed fall while attempting to self toilet. The resident was found on the floor between the toilet and the sink with her walker in front of her.</p> <p>The Interdisciplinary Team (IDT) reviewed that fall on 4/30/24. Toilet rise to be placed on toilet was added to the care plan.</p> <p>A fall risk assessment, dated 4/29/24, indicated Resident S was at high risk for falls.</p> <p>Fall 2</p> <p>A 72-hour charting note, dated 6/3/24 at 9:56 A.M., indicated Resident S was assessed for a fall. The note did not indicate when, where, or how the fall took place.</p> <p>The clinical record lacked documentation regarding the fall that took place on 6/3/24.</p> <p>The clinical record lacked documentation to indicate the physician and responsible party were notified of that fall.</p> <p>The clinical record lacked an IDT note about that fall.</p> <p>The care plan was not updated with a new intervention.</p> <p>A fall risk assessment was not completed.</p> <p>Fall 3</p> <p>On 6/6/24 at 8:45 A.M., Resident S had a witnessed fall while attempting to pick something up off the bed.</p> <p>The clinical record lacked an IDT note about that fall.</p> <p>The care plan was not updated with a new intervention.</p> <p>A fall risk assessment, dated 6/6/24, indicated Resident S was at high risk for falls.</p> <p>Fall 4</p> <p>On 6/8/24 at 1:45 P.M., Resident S had an unwitnessed fall while attempting to self toilet. The resident was found on the floor.</p> <p>The clinical record lacked an IDT note about that fall.</p> <p>The care plan was not updated with a new intervention.</p> <p>A fall risk assessment, dated 6/8/24, indicated Resident S was at high risk for falls.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Fall 5</p> <p>On 6/11/24 at 11:30 A.M., Resident S had an unwitnessed fall while attempting to self toilet. She was found sitting on the bedroom floor next to her bed with her walker next to her.</p> <p>The clinical record lacked an IDT note about that fall.</p> <p>The care plan was not updated with a new intervention.</p> <p>A fall risk assessment, dated 6/11/24, indicated Resident S was at high risk for falls.</p> <p>Fall 6</p> <p>On 6/28/24 at 4:30 P.M., Resident S had an unwitnessed fall while attempting to self toilet. She was found on the floor near the foot of the bed.</p> <p>The clinical record lacked an IDT note about that fall.</p> <p>Psych med review per [name of mental health provider] NP was added to the care plan on 6/28/24.</p> <p>A fall risk assessment, dated 6/28/24, indicated Resident S was at high risk for falls.</p> <p>Fall 7</p> <p>On 7/2/24 at 9:35 A.M., Resident S had an unwitnessed fall while attempting to peel up the non skid strips from the floor. The resident was found sitting on the floor by her bed.</p> <p>The clinical record lacked an IDT note about that fall.</p> <p>Non-skid strips replaced at bedside was added to the care plan on 7/2/24.</p> <p>A fall risk assessment, dated 7/2/24, indicated Resident S was at high risk for falls.</p> <p>Fall 8</p> <p>On 7/3/24 at 2:00 A.M., Resident S had an unwitnessed fall. The resident slid out of bed and was found sitting on the floor by her bed.</p> <p>The IDT reviewed that fall on 7/3/24. Bolsters placed on bed was added to the care plan.</p> <p>A fall risk assessment was not completed.</p> <p>A mental health provider note, dated 7/9/24, indicated mental health medications were reviewed and no medication changes were made.</p> <p>Fall 9</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 7/14/24 at 7:15 P.M., Resident S had a witnessed fall while attempting to sit up straight. She slid out of bed.</p> <p>The clinical record lacked an IDT note about that fall.</p> <p>Staff to encourage/assist resident with laying in bed with feet elevated rather than sit on the side leaning over the bed was added to the care plan on 7/14/24.</p> <p>A fall risk assessment was not completed.</p> <p>Fall 10</p> <p>On 7/18/24 at 1:51 P.M., Resident S had an unwitnessed fall while attempting to self toilet. She was found sitting on the floor at the entrance to her bathroom.</p> <p>The clinical record lacked an IDT note about that fall.</p> <p>The care plan was not updated with a new intervention.</p> <p>A fall risk assessment was not completed.</p> <p>Fall 11</p> <p>On 7/22/24 at 2:25 P.M., Resident S had an unwitnessed fall while attempting to self toilet. She was found sitting on the floor in her room.</p> <p>The clinical record lacked documentation to indicate the physician was notified of that fall.</p> <p>The clinical record lacked an IDT note about that fall.</p> <p>Staff to offer opportunities for 1:1 activities throughout the day was added to the care plan on 7/22/24.</p> <p>A fall risk assessment, dated 7/22/24, indicated Resident S was at high risk for falls.</p> <p>Fall 12</p> <p>On 7/23/24 at 8:15 A.M., Resident S had an unwitnessed fall while attempting to self toilet. She was found sitting on her bedroom floor with her walker in front of her.</p> <p>The clinical record lacked an IDT note about that fall.</p> <p>The care plan was not updated with a new intervention.</p> <p>A fall risk assessment, dated 7/23/24, indicated Resident S was at high risk for falls.</p> <p>Fall 13</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 8/4/24 at 6:20 P.M., Resident S had an unwitnessed fall while in her room. The resident was found sitting on the floor in the doorway to her room.</p> <p>The IDT reviewed that fall on 9/11/24.</p> <p>The care plan was not updated with a new intervention.</p> <p>A fall risk assessment, dated 8/4/24, indicated Resident S was at high risk for falls.</p> <p>Fall 14</p> <p>On 8/5/24 at 11:20 A.M., Resident S had an unwitnessed fall while attempting to self toilet. The resident was found sitting on the floor in the doorway to her room.</p> <p>The IDT reviewed that fall on 9/11/24. Review information on past falls and attempt to determine cause of falls. Record possible root causes. Educate resident/family/caregivers/IDT as to causes was added to the care plan on 8/12/24.</p> <p>The clinical record lacked documentation to indicate a review was completed, possible root causes for the resident's falls were determined, and education about those causes were provided.</p> <p>A fall risk assessment, dated 8/5/24, indicated Resident S was at high risk for falls.</p> <p>Fall 15</p> <p>On 8/28/24 at 12:30 P.M., Resident S had an unwitnessed fall while attempting to self toilet. A CNA responded to the resident's call light and found her sitting on the floor with her walker next to her.</p> <p>The clinical record lacked an IDT note about that fall.</p> <p>Remove non-skid strips from floor as these appear to be more of a hazard to her as she is always leaned over picking at them and pulling them up, putting her at an increased risk for falls was added to the care plan on 8/28/24.</p> <p>A fall risk assessment, dated 8/28/24, indicated Resident S was at high risk for falls.</p> <p>Fall 16</p> <p>On 8/29/24 at 1:20 P.M., Resident S had an unwitnessed fall while attempting to self toilet. The resident was found sitting in the bathroom with her wheelchair close to her. She had a skin tear on her right forearm.</p> <p>The IDT reviewed that fall on 9/11/24. Re-educate nursing staff on offering assistance to resident with toileting and her safety checks was added to the care plan.</p> <p>A fall risk assessment, dated 8/29/24, indicated Resident S was at high risk for falls.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Fall 17</p> <p>On 10/13/24 at 11:30 P.M., Resident S had an unwitnessed fall while in the dayroom. She was found lying on the floor in front of her wheelchair.</p> <p>The clinical record lacked an IDT note about that fall.</p> <p>The care plan was not updated with a new intervention.</p> <p>A fall risk assessment was not completed.</p> <p>Fall 18</p> <p>On 10/18/24 at 12:10 A.M., Resident S had an unwitnessed fall while walking with her walker. The resident was found sitting on the floor at the entrance to her room. The walker was broken on one side.</p> <p>The clinical record lacked an IDT note about that fall.</p> <p>The care plan was not updated with a new intervention.</p> <p>A fall risk assessment, dated 10/18/24, indicated Resident S was at high risk for falls.</p> <p>Fall 19</p> <p>On 10/27/24 at 2:15 A.M., Resident S had an unwitnessed fall while in her room. The resident was found sitting on the floor in her room in front of her wheelchair.</p> <p>The clinical record lacked an IDT note about that fall.</p> <p>The care plan was not updated with a new intervention.</p> <p>A fall risk assessment, dated 10/27/24, indicated Resident S was at high risk for falls.</p> <p>Fall 20</p> <p>On 11/27/24 at 6:00 P.M., Resident S had a witnessed fall while attempting to self toilet.</p> <p>The IDT reviewed that fall on 12/3/24. Therapy to screen/evaluate resident for safe self transfers was added to the care plan.</p> <p>A fall risk assessment, dated 11/27/24, indicated Resident S was at high risk for falls.</p> <p>An Occupational Therapy evaluation and plan of treatment, dated 12/3/24, indicated Resident S was certified to receive therapy two to three times a week from 12/3/24 until 1/1/25.</p> <p>Fall 21</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 12/4/24 at 8:45 A.M., Resident S had an unwitnessed fall while getting up from her chair. She was found sitting on her bedroom floor next to her chair.</p> <p>The IDT reviewed that fall on 1/8/25. Therapy to trial assistive device to help assist with proper functioning and Environmental room check for furniture placement to better suit resident's needs were added to the care plan.</p> <p>A fall risk assessment was not completed.</p> <p>Fall 22</p> <p>On 12/8/24 at 1:17 A.M., Resident S had an unwitnessed fall in her room. The resident was found on the floor adjacent to her bed.</p> <p>The clinical record lacked documentation to indicate the physician and responsible party were notified of that fall.</p> <p>The cli</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p>48147</p> <p>Based on observation, interview, and record review, the facility failed to provide nutritional care and services including failure to identify significant weight loss, failure to notify the physician of significant weight loss, and failure to be reviewed by the Registered Dietician for 1 of 1 residents reviewed for weight loss (Resident S).</p> <p>Finding includes:</p> <p>On 4/4/25 at 12:40 P.M., Resident S's clinical record was reviewed. Diagnoses included, but were not limited to, dementia, diabetes mellitus, and dysphagia.</p> <p>The most current Annual Minimum Data Set (MDS) Assessment, dated 2/5/25, indicated Resident S had severe cognitive impairment, required setup assistance from staff for eating, weighed 179 pounds (lbs), and had no weight loss.</p> <p>The most current Quarterly MDS Assessment, dated 2/20/25, indicated Resident S had severe cognitive impairment, required setup assistance from staff for eating, weighed 132 lbs, and had no weight loss.</p> <p>The most recent care plan conference was completed on 11/14/24. The care plan was reviewed and updated.</p> <p>A current nutritional status care plan, revised on 10/26/22, indicated Resident S was at risk for altered nutritional status.</p> <p>Current physician orders included, but were not limited to:</p> <p>mirtazapine (Remeron) oral tablet 15 milligrams (mg) - Give one tablet by mouth at bedtime related to major depressive disorder, dated 1/30/2025</p> <p>Namenda tablet 5 mg - Give one tablet by mouth one time a day related to dementia, dated 1/30/25</p> <p>A review of the weights and vitals tab indicated Resident S was weighed on the following days:</p> <p>4/5/24 - 192.2 lbs standing</p> <p>5/8/24 - 186.6 lbs standing</p> <p>6/7/24 - 183.4 lbs standing</p> <p>7/10/24 - 182.1 lbs standing</p> <p>8/9/24 - 183.6 lbs standing</p> <p>9/9/24 - 181.2 lbs standing</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>10/10/24 - 178.8 lbs wheelchair</p> <p>12/16/24 - 179.0 lbs wheelchair</p> <p>1/3/25 - 179.3 lbs standing</p> <p>2/18/25 - 131.7 lbs wheelchair (a 26.55% weight loss)</p> <p>A nursing progress note, dated 1/29/25 at 3:20 P.M., indicated the mental health Nurse Practitioner (NP) reviewed the resident's mental health medications on 1/28/25. Namzaric (a medication used to slow the progression of dementia with a side effect of anorexia) was discontinued due to not eating and weight loss. Remeron (an antidepressant medication with side effects of increased appetite and weight gain) was decreased from 45 mg at bedtime to 15 mg at bedtime. Namenda (a medication used to slow the progression of dementia without the anorexia side effect) 5 mg daily was ordered.</p> <p>A psychiatry encounter progress note, dated 2/24/25 at 11:00 P.M., included a weight loss warning and indicated the patient was tolerating the previous medication changes. No medication changes were made at that visit.</p> <p>A psychiatry encounter progress note, dated 3/11/25 at 12:00 A.M., indicated that the resident had a significant weight loss and to have staff re-weigh the resident.</p> <p>A psychiatry encounter progress note, dated 3/25/25 at 12:00 A.M., indicated that the resident had a significant weight loss and to have staff re-weigh the resident. It indicated the mental health provider was waiting for the March weight.</p> <p>The clinical record lacked documentation to indicate the resident was re-weighed after the 2/18/25 weight was taken.</p> <p>The clinical record lacked documentation to indicate the resident was referred to the dietitian for weight loss.</p> <p>The clinical record lacked a nutritional assessment of the resident by the dietitian.</p> <p>The clinical record lacked notification to the physician about the resident's significant weight loss.</p> <p>The clinical record lacked documentation to indicate the resident was reviewed by the Interdisciplinary Team (IDT) for weight loss.</p> <p>On 4/4/25 at 1:56 P.M., Resident S was observed sitting in her wheelchair in the hallway. The strap of her shirt was hanging over her shoulder. At that time, the resident indicated that she had lost a lot of weight, and her clothes did not fit anymore. She was not sure why she had lost weight.</p> <p>On 4/8/25 at 2:51 P.M., CNA 18 weighed Resident S. The resident weighed 162.8 lbs including the wheelchair weight. The wheelchair's weight was 39.5 lbs. CNA 18 confirmed Resident S currently weighed 123.3 lbs (a 6.38% weight loss since 2/18/25 and a 31.23% weight loss since 1/3/25).</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 4/8/25 at 3:43 P.M., the Director of Nursing (DON) indicated that the Registered Dietitian (RD) ran monthly reports to know which residents to follow for weight loss. The facility's Nurse Practitioner (NP) also reviewed charts monthly for weight loss. At that time, the DON indicated she was unable to find any notes from the RD or NP regarding Resident S's weight loss. The only notes she could find related to Resident S's weight loss were from the mental health NP.</p> <p>On 4/9/25 at 9:19 A.M., the MDS Coordinator indicated that the resident had a weight loss and it should have been coded as such on the Quarterly MDS Assessment, but the weight loss did not trigger and the dietitian did not reach out to her.</p> <p>On 4/9/25 at 12:14 P.M., the DON provided a current Regional Dietitian Consultant job description, dated 7/3/17, that indicated Essential Duties and Responsibilities: . Assesses the nutritional status of customers inclusive of .weight maintenance . Ensures appropriate documentation of nutritional assessment and recommended intervention in the customer chart and/or care plan; reviews the documentation of others regarding nutritional concerns and responds appropriately.</p> <p>On 4/9/25 at 12:14 P.M., the DON provided a current Weights policy, revised 10/17/19, that indicated Each resident shall be weighed on admission and at least monthly thereafter, or in accordance with Physician orders or plan of care . Re-weight should be obtained if there is a difference of 5 lbs or greater (loss or gain) since previous recorded weight . Undesired or unanticipated weight gains/loss of 5% in 30 days, 7.5% in three months, or 10% in six months shall be reported to the physician, Dietician and/or Dietary Manager as appropriate.</p> <p>This citation relates to Complaint IN00449780.</p> <p>3.1-46(a)(1)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155820	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/09/2025
NAME OF PROVIDER OR SUPPLIER Aperion Care Lincoln		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.</p> <p>48147</p> <p>Based on observation, interview, and record review, the facility failed to ensure physician orders were followed and a resident's nutritional feedings were administered for 1 of 1 residents reviewed for tube feedings. A resident's enteral nutrition refusals were not documented, and feeding equipment was not changed daily. (Resident G)</p> <p>Finding includes:</p> <p>On 4/3/25 at 11:44 A.M., Resident G was observed sitting in her wheelchair in her room. Jevity (tube feeding) formula, dated 4/2/25, was observed in the room but was not hooked up to the resident. A syringe was observed hanging in a bag and was dated 4/1/25.</p> <p>On 4/4/25 at 1:24 P.M., the enteral nutrition was observed turned off in Resident G's room. Resident G was not in her room at that time. A syringe was observed hanging in a bag and was dated 4/1/24.</p> <p>On 4/7/25 at 11:37 A.M., the enteral nutrition was observed turned off in Resident G's room. Resident G was not in her room at that time. The feeding tube was wrapped around the pole and there was no cap on the end of the tubing.</p> <p>On 4/8/25 at 10:57 A.M., the enteral nutrition was observed turned off in Resident G's room. Resident G was not in her room at that time.</p> <p>On 4/8/25 at 2:43 P.M., the enteral nutrition was observed turned off in Resident G's room. Resident G was not in her room at that time.</p> <p>On 4/7/25 at 11:16 A.M., Resident G's clinical record was reviewed. Diagnoses included, but were not limited to, pneumonitis due to inhalation of food and vomit, dysphagia, and dementia.</p> <p>The most current Significant Change Minimum Data Set (MDS) Assessment, dated 3/17/25, indicated Resident G had mild cognitive impairment, was dependent on staff (staff does all of the effort) for transfers, and the resident received 51% or more of her nutrition through a feeding tube.</p> <p>The most recent care conference was completed on 2/27/25. The care plans were reviewed and updated.</p> <p>A current tube feeding care plan, initiated 3/17/25, included an intervention to monitor caloric intake.</p> <p>Current physician orders included, but were not limited to:</p> <p>Nothing By Mouth (NPO) diet - may have four ounces (oz) cups of ice chips at bedside and per her request for dysphagia following cerebral infarction, dated 3/14/25</p> <p>(continued on next page)</p>		

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Continuous Enteral Feeding: Formula: Jevity 1.5 at 60 milliliters (ml) per hour for 22 hours per day (1320 ml total), off for 2 hours per day Activities of Daily Living (ADLs); Flush with 250 ml of water every six hours. Monitor every shift, dated 3/25/25.</p> <p>Change Syringe every 24 hours and as needed, dated 3/14/25</p> <p>The Medication Administration Record (MAR) for the continuous enteral feeding for March and April was reviewed. The record included, but was not limited to:</p> <p>3/14/25 - 180 (evening); 360 (night) - 540 (total)</p> <p>3/15/25 - 50 (day); 50 (evening); 400 (night) - 500 (total)</p> <p>3/16/25 - 50 (day); 50 (evening); 400 (night) - 500 (total)</p> <p>3/17/25 - not documented (day); 360 (evening); 480 (night) - 840 (total)</p> <p>3/18/25 - order (day); 420 (evening); 390 (night) - unable to be calculated</p> <p>3/19/25 - 370 (day); 50 (evening); 295 (night) - 715 (total)</p> <p>3/20/25 - 477 (day); 60 (evening); 400 (night) - 937 (total)</p> <p>3/21/25 - 600 (day); 60 (evening); 390 (night) - 1050 (total)</p> <p>3/22/25 - 365 (day); 1320 (evening); 400 (night) - 2085 (total)</p> <p>3/23/25 - 420 (day); 1320 (evening); 46 (night) - 1786 (total)</p> <p>3/24/25 - 350 (day); 420 (evening); 395 (night) - 1165 (total)</p> <p>3/25/25 - 330 (day); 360 (evening); 460 (night) - 1150 (total)</p> <p>3/26/25 - NA (day); 1320 (evening); 480 (night) - 1800 (total)</p> <p>3/27/25 - 350 (day); resident refused (evening); 400 (night) - 750 (total)</p> <p>3/28/25 - 360 (day); 360 (evening); 480 (night) - 1200 (total)</p> <p>3/29/25 - 500 (day); 360 (evening); NA (night) - 860 (total)</p> <p>3/30/25 - 440 (day); 360 (evening); 480 (night) - 1280 (total)</p> <p>3/31/25 - 360 (day); y (evening); 480 (night) - total unable to be calculated</p> <p>4/1/25 - 360 (day); 1122 (evening); NA (night) - 1482 (total)</p> <p>4/2/25 - 60/hr (day); 1.5 (evening); NA (night) - total unable to be calculated</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Aperion Care Lincoln		STREET ADDRESS, CITY, STATE, ZIP CODE 1236 Lincoln Ave Evansville, IN 47714	
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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>4/3/25 - 60 (day); 480 (evening); 460 (night) - 1000 (total)</p> <p>4/4/25 - 360 (day); 60 (evening); NA (night) - 420 (total)</p> <p>4/5/25 - 360 (day); 360 (evening); 460 (night) - 1180 (total)</p> <p>4/6/25 - 240 (day); 480 (evening); 460 (night) - 1180 (total)</p> <p>The clinical record lacked notification to the physician when the resident received more or less than the ordered 1320 ml of formula in a 24 hour period.</p> <p>The clinical record lacked documentation that the enteral nutrition was turned off or that the resident refused nutrition on 4/3/25, 4/4/25, 4/7/25, and 4/8/15 outside of the two hours ordered by the physician.</p> <p>On 4/8/25 at 1:45 P.M., the Director of Nursing (DON) indicated that Resident G sometimes refused her enteral nutrition. She indicated that all refusals should be documented and that the physician would be notified if there was an extended refusal.</p> <p>On 4/8/25 at 3:43 P.M., the DON provided all documented refusals of enteral nutrition. She indicated she could only find two documented refusals and subsequent notifications to the physician dated 3/14/25 at 5:29 P.M. and 4/6/25 at 3:11 P.M.</p> <p>On 4/9/25 at 12:14 P.M., the DON provided a current Enteral Nutrition (EN) - Tube Feeding policy, dated 2020, that indicated Nursing staff will follow the community enteral nutrition policies and guidelines . Close monitoring of tube feeding tolerance, intake and output records, nursing notations on physical assessment for characteristics such as skin turgor, available labs, etc. are essential to ensure adequate fluids are being provided.</p> <p>On 4/9/25 at 12:14 P.M., the DON provided a current Physician-Family Notification- Change in Condition policy, revised 11/13/18, that indicated The facility will inform .consult with the resident's physician .when there is: . a need to alter treatment .</p> <p>On 4/9/25 at 12:14 P.M., the DON provided a current undated Documentation Procedures and Guidelines policy that indicated Each health care professional shall be responsible for making their own prompt, factual, concise, entries that are complete, appropriate, and readable . Entries will be made whenever there is a change in the resident's condition. The entry will include interventions and appropriate notifications made in a timely manner.</p> <p>On 4/9/25 at 1:30 P.M., the Regional Nurse indicated it was the facility's policy to follow the physician orders.</p> <p>3.1-44(a)(2)</p>		

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<p>F 0760</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>48057</p> <p>Based on record review and interview, the facility failed to ensure residents were free from significant medication errors for 1 of 2 residents reviewed for hospitalization . A resident did not receive blood pressure medications and was admitted to the hospital two times for hypertensive emergencies. (Resident B)</p> <p>Finding includes:</p> <p>On 4/7/25 at 9:24 A.M., Resident B's clinical record was reviewed. Diagnoses included, but were not limited to, hypertensive encephalopathy.</p> <p>The most recent Annual Minimum Data Set assessment, dated 1/3/25, indicated Resident B was moderately cognitively intact.</p> <p>Care plans included, but were not limited to:</p> <p>Resident had a diagnosis of hypertension: Administer medications as ordered; Assess for side effects and effectiveness; Notify physician of noted signs/symptoms for further evaluation, initiated 2/17/24.</p> <p>Physician orders included, but were not limited to:</p> <p>Carvedilol (a medication used to treat high blood pressure) oral tablet 12.5 mg (milligrams) give one tablet by mouth two times a day for hypertension; Start date 2/9/24</p> <p>Isosorbide Mononitrate (a medication used to treat high blood pressure) ER (extended release) oral tablet 60 mg give one tablet by mouth two times a day for paroxysmal atrial fibrillation; Start date 2/9/24</p> <p>Lisinopril (a medication used to treat high blood pressure) oral tablet 10 mg give one tablet by mouth two times a day for hypertension; Start date 2/9/24</p> <p>Clonidine (a medication used to treat high blood pressure) HCl Oral Tablet 0.1 mg give one tablet by mouth three times a day for hypertension, hold if systolic blood pressure is less than 160; Start date 3/26/24 Discontinued 7/3/24</p> <p>The electronic medication administration record (MAR) indicated Resident B did not receive his blood pressure medications (Carvedilol 12.5 mg, Isosorbide Mononitrate ER 60 mg, or Lisinopril 10 mg) at 8:00 A. M. on 6/25/24. in accordance with the physician orders.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>A nursing progress note, dated 6/25/24 at 2:06 P.M., indicated Resident B was heard yelling from his bedroom, the CNA went to check on him, and found him kneeling with his elbows on the floor in front of the toilet, and his rollator was next to him. The resident was barefoot, this nurse and two CNAs assisted him to lie down in a comfortable position. This nurse then assessed the resident for injury and none was observed at this time. This nurse and two CNAs then tried to assist the resident off the floor but the resident started complaining of back and neck pain, the nurse then decided not to move the resident and notified triage (a physician communication line). Triage gave an order to send the resident to the emergency room , ambulance was called and came to assist the resident off the floor and transported him to the hospital. The blood pressure was 155/84.</p> <p>A hospital admission history, dated 6/25/24 at 10:10 A.M., indicated Resident B's blood pressure was 240/103 on admission and resident had a hypertensive emergency with encephalopathy- likely due to not receiving proper medication regimen in nursing home.</p> <p>On 10/1/24 a new physician's order for hydralazine (a medication used to treat high blood pressure) HCl oral tablet 25 mg give 1 tablet by mouth every eight hours as needed was initiated.</p> <p>The electronic medication administration record (MAR) indicated Resident B did not receive his previous doses of blood pressure medications (Carvedilol 12.5 mg, Isosorbide Mononitrate ER 60 mg, Lisinopril 10 mg) on 12/7/24 at 8:00 P.M., and did not have a blood pressure recorded or blood pressure medications (Hydralazine 50 mg) given on 12/7/24 at 4:00 P.M.</p> <p>A nurses note, on 12/8/24 at 4:04 A.M., indicated Resident B was having chest pain and was given nitroglycerin (medication used to treat chest pain).</p> <p>A nurses note, on 12/8/24 at 6:00 A.M., indicated Resident B had been transported to the hospital.</p> <p>A hospital history and physician note, dated 12/8/24 at 11:30 A.M., indicated Resident B's blood pressure was 224/174 and he was having a hypertensive emergency.</p> <p>During an interview on 4/8/25 at 1:23 P.M., the Director of Nursing (DON) indicated each resident had different blood pressure parameters to notify the physician about, nursing staff should use their nursing judgement if a blood pressure falls outside of normal parameters, and that the charting system flags systolic blood pressure above 139 as elevated.</p> <p>On 4/9/25 at 12:14 P.M., a policy relating to blood pressure parameters and following physician orders was requested and not provided.</p> <p>During an interview on 4/9/25 at 1:20 P.M., the regional nurse indicate the policy of the facility was for staff to follow physician orders.</p> <p>3.1-48(c)(2)</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>46758</p> <p>Based on observation, record review, and interview, the facility failed to ensure food that was served at palatable temperature for 1 of 1 trays tested for food temperature.</p> <p>Findings include:</p> <p>On 4/7/35 at 12:50 P.M., a hall tray was obtained on the 200 Unit. The following temperatures were observed:</p> <p>Carrots-115 degrees F</p> <p>During an interview on 4/7/25 at 12:45, the Dietary Manager indicated that the holding temperatures on the steam table should be 145 degrees F or higher.</p> <p>On 4/9/25 at 12:14 P.M., The Director of Nursing (DON) provided a current, non-dated policy Monitoring Food Temperatures for Meal Service. The policy indicated . food temperatures will be monitored to prevent foodborne illness and ensure foods are served at palatable temperatures .serving/holding temperatures require 140 minimum when checked prior to meal service .meals that are served on room trays .prefer hot foods to be at 120 degrees F or greater for the palatability for the resident .</p> <p>This citation relates to Complaint IN00449780.</p> <p>3.1-21(a)(2)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46758</p> <p>Based on observation, interview, and record review, the facility failed to ensure food was stored in sanitary manner for 1 of 2 kitchen observations. Food containers were not labeled in the reach in refrigerator and dry storage.</p> <p>Findings include:</p> <p>On 4/3/25 at 10:35 A.M., the following was observed in the dry storage area:</p> <ul style="list-style-type: none"> - One bag of [NAME] noodles with no open date - One bag of marshmallows with no open date <p>On 4/3/25 at 10:57 A.M., the following was observed in the reach in refrigerator:</p> <ul style="list-style-type: none"> - One container of orange juice without preparation date or use by date - One container of apple juice without a preparation date or use by date - One green container with orange colored fluid without a label, preparation date, or use by date - One pink container with brown colored fluid without a label, preparation date, or use by date - One clear container with purple colored fluid without a label, preparation date, or use by date - Two green colored containers with fluid, without a label, preparation date, or use by date - One yellow container with fluid, without a label, preparation date, or use by date <p>During an interview on 4/8/25 at 9:31 A.M., the Dietary Manager indicated containers should be labeled and have a preparation and use by date.</p> <p>On 4/9/25 at 12:14 P.M., the Director of Nursing provided a current, non-dated policy Food Storage (Dry, Refrigerated, and Frozen). The policy indicated the general storage guidelines including all food items will be labeled. The label must include the name of the food and the date it should be consumed by .</p> <p>3.1-21(i)(2)</p> <p>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>46758</p> <p>Based on observation, record review, and interview, the facility failed to ensure infection control practices were implemented for 2 of 3 residents observed for care. Gloves were not changed and hand hygiene was not performed. (CNA 23, RN 28, RN 7)</p> <p>Findings include:</p> <p>1. On 4/8/25 at 10:42 A.M., incontinence care was observed for Resident 22. CNA 23 sanitized with hand sanitizer and donned gloves while RN 28 only donned gloves. CNA 23 gathered supplies with the gloves on, turned the resident to the right side, and removed the resident's sweatpants and soiled brief. CNA 23 provided incontinence care using three wash cloths and turned the resident to the left side, then RN 28 completed the incontinence care with two more washcloths. RN 28 removed the soiled gloves and washed hands with soap and water. CNA 23 utilized the same gloves to place barrier cream on Resident 22. CNA 23 wiped the gloved hands with the barrier clean inside the clean incontinence brief and then put the clean incontinence brief on Resident 22.</p> <p>48057</p> <p>2. During an observation of wound care on 4/9/25 at 11:40 A.M., RN 7 gathered supplied and entered Resident F's room. RN 7 applied hand sanitizer, put a gown and gloves on, and cut Resident F's dressing off. The dressing was dated 4/7. RN 7 cleansed the wound with wound cleanser on gauze, applied skin prep, HydraLock SA (absorbent dressing), and wrapped the left foot in Kerlex (gauze wrap). RN 7 taped the Kerlex in place and dated the dressing 4/9, removed her gown and gloves, put a new pair of gloves on, and put a heel boot on Resident F's left foot. RN 7 gathered the trash, gloves, and exited Resident F's room. RN 7 did not perform hand hygiene during or after performing wound care.</p> <p>During an interview on 4/9/25 at 9:37 A.M., the Infection Preventionist Nurse indicated that gloves should be changed and hand hygiene should be performed when visibly soiled and in between going from dirty to clean tasks.</p> <p>On 4/9/25 at 12:14 P.M., the Director of Nursing (DON) provided a current, revised 1/31/18 Glove Use-Nursing The policy indicated . non-sterile gloves shall be worn for procedures involving contact with mucus membranes and for resident care .requiring direct contact with body fluids .examples may include . incontinence care .handling of linens, clothing, or other materials soiled with body fluids or blood . Gloves used for contact shall be removed and discarded with each person. fluid item or surface . Hand hygiene will be performed after removing gloves .</p> <p>3.1-18(b)(1)</p>		

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<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>48147</p> <p>Based on interview and record review, the facility failed to ensure designation of a certified Infection Preventionist (IP). The IP did not currently dedicate at least part time hours to the role of IP for 1 of 1 staff members reviewed for IP.</p> <p>Finding includes:</p> <p>On 4/9/25 at 9:30 A.M., the DON's employee file was reviewed. The employee file lacked a signed job description for the Infection Preventionist role.</p> <p>On 4/9/25 at 9:37 A.M., the DON indicated she was currently responsible for the infection prevention and control program in the facility. She indicated she also worked full time in the facility as the DON.</p> <p>On 4/9/25 at 12:14 P.M., the DON provided a current Infection Preventionist job description, dated 4/14/22, that indicated Reports to: Director of Nursing and/or Administrator . 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.</p> <p>On 4/9/25 at 12:14 P.M., the DON provided a current Director of Nursing job description, dated 5/2/17, that indicated The primary purpose of the Director of Nursing position is to plan, organize, develop and direct the overall operation of our Nursing Department in accordance with current federal, state, and local standards, guidelines, and regulations that govern our facility.</p>		