STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155799	A. BUILDING 00 B. WING	02/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
APERION CARE MARION LLC	614 WEST 14TH STREET MARION, IN 46953

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00425927 and IN00427758. Complaint IN00425927 - Federal/State deficiencies related to the allegations are cited at F550, F942, F943, F9999. Complaint IN00427758 - Federal/State deficiencies related to the allegations are cited at F726. Survey dates: February 7 and 8, 2024. Facility number: 012809 Provider number: 155799 AIM number: 201136580 Census Bed Type: SNF/NF: 57 SNF: 2 Total: 59 Census Payor Type: Medicare: 2 Medicaid: 38 Other: 19 Total: 59 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed February 15, 2024.	F 0000		
F 0550 SS=D Bldg. 00	483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Tamera Shirels | ED | 02/28/2024

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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.

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	communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. Based on observation, interview, and record review, the facility failed to honor a resident's	F 0550	**Tag number: F 550** I What corrective	02/29/2024

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	preference to utilize a foot pedal for her wheelchair for 1 of 3 resident reviewed for resident rights. (Resident C) Findings include: Resident C's clinical record was reviewed on 2/7/24 at 11:25 a.m. Diagnoses included embolism and thrombosis of other specified veins, recurrent, unsteadiness on feet, need for assistance with personal care, other abnormalities of gait and mobility, and unspecified fracture of shaft of right tibia (lower leg bone), subsequent encounter for closed fracture with routine healing. Her orders included fondaparinux sodium (blood thinner) 0.4 milliliter subcutaneously daily and weight bearing as tolerated to her right lower extremity. During an interview with Resident C, on 2/7/24 at 12:18 p.m., she indicated she had broken her right leg, it was swollen from the knee down, and she couldn't put the brace on it for her foot drop (unable to flex foot toward knee). She wanted to be able to put her foot up because of the swelling. They told her to elevate her leg and the only time she could do that was when she was in bed. The Administrator said she needed to use her right foot more, so she took the resident's right foot pedal off of her wheelchair and put it in her office. She walked in therapy, but not in her room, as she was not stable on her right leg. During an interview with the Administrator, on 2/7/24 at 12:53 p.m., she indicated Resident C came to the facility due to a broken ankle after a fall and she became very handicapped. She wouldn't do what therapy wanted her to do, and she kept saying she couldn't walk. She developed foot		action(s) will be accomplished for those residents found to have been affected by the deficient practice. **Resident C's foot pedal was returned to her wheelchair as her preference.** II How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; **All residents will be interviewed to ensure their preferences and resident rights are being met. Any reasonable preferences not being met or resident's rights that are being violated will be corrected. Updated preferences will be added to the resident's care plan.** . III What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; **All staff will be educated on resident rights including preferences and the process for reporting potential violations of resident rights. The nursing staff will be educated on charting and communicating resident preferences. Resident preferences will be identified during the care planning process and reviewed during**	

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	drop. She was full weightbearing and refused to walk in her room. She used her wheelchair for mobility, but she was very capable of using her walker according to the therapy department. She (the Administrator) took the wheelchair leg away from Resident C, since it was a therapy intervention to use that foot and leg. During an interview with Physical Therapist 2, on 2/7/24 at 2:52 p.m., he indicated Resident C came to the facility with a right fractured ankle. It healed, and she was now full weight bearing. She was self-limiting. She felt she had swelling in her leg, and it was still painful. When she felt good, she could walk around the room and had gotten to the point where she used a quad cane or a walker with stand-by assistance. She had good potential to get better, but she limited herself. She could be steady when she wanted to, but it was voluntary. She used the wheelchair for mobility. They didn't want her leg to be up on the leg rest, as they wanted her to use her leg to propel herself. She could put her leg up when she got back to her room. She had damage to a nerve which caused the partial foot drop, and she had been educated the advantage of using her legs while in her wheelchair. A current facility policy, dated 8/23/17, provided on the conference room table on 2/8/24 at 3:41 p.m., titled "Resident Rights," indicated the following: "...Exercising rights means that residents have autonomy and choice, to the maximum extent possible, about how they wish to live their everyday lives and receive care, subject to the facility's rules, as long as those rules do not violate a regulatory requirement...." This citation relates to Complaint IN00425927.		**care plan meetings and upon request. Therapy will also help to identify preferences while working with the residents. Therapy will educate, if needed, any recommendations from them to the residents, but will go with the resident preference.** IV How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; The DON or designee will interview 15 residents weekly x 4 weeks then 5 residents weekly x 4 weeks and then 10 residents monthly to ensure resident rights are being met. **The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.**	

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	3.1-3(u)(3)			
F 0726 SS=D Bldg. 00	483.35(a)(3)(4)(c) Competent Nursing Staff §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. Based on observation, interview, and record review, the facility failed to ensure competent treatement for a pressure injury was completed	F 0726	Tag number: F 726 I What corrective action(s) will be accomplished for	02/29/2024

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	according to physician's orders for 1 of 2 residents reviewed for wound care. (Resident D) Findings include: Resident D's clinical record was reviewed on 2/7/24 at 3:26 p.m. Diagnoses included methicillin susceptible staphylococcus aureus infection as the cause of diseases classified elsewhere, type 2 diabetes mellitus with diabetic neuropathy and peripheral vascular disease. His physician's orders included Santyl ointment (enzymatic debridement), apply to right heel topically daily. Wash wound with wound cleanser, pat dry, apply to wound bed, cover with nonstick pad, and wrap with Kerlix. He had an unstageable (full-thickness pressure injuries in which the base is obscured by slough and/or eschar) pressure ulcer to his right heel that measured 2.5 cm (centimeters) length by 3.5 cm width. During a wound care observation for Resident D, on 2/7/24 at 2:34 p.m., LPN 15 applied medical grade honey (autolytic debridement) with a gauze pad to the resident's pressure injury to his right heel. He covered the heel with an abdominal pad and wrapped his heel and ankle with gauze wrap. During an interview with LPN 15, on 2/8/24 at 10:16 a.m., he indicated he realized he used the wrong treatment for Resident C afterwards. He had no idea why he grabbed the medical honey and not the Santyl, but he did look at the order prior to completing the treatment. This citation relates to Complaint IN00427758.		those residents found to have been affected by the deficient practice; Resident D was assessed and MD was notified of the incorrect treatment. II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; Residents with wound treatment orders were reviewed and in place, treatment was assessed to insure they were receiving the correct physician ordered wound treatment. III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; ; The Nurses were in-serviced on following the Physician orders for all wound treatments. IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; The wound nurse/designee will randomly observe 7 wound treatments a week x 4 week, then 5 residents weekly x 4 weeks and	

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			then 6 residents monthly to ensure orders are being followed. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	
F 0942 SS=D Bldg. 00	483.95(b) Resident Rights Training §483.95(b) Resident's rights and facility responsibilities. A facility must ensure that staff members are educated on the rights of the resident and the responsibilities of a facility to properly care for its residents as set forth at §483.10, respectively. Based on interview and record review, the facility failed to ensure annual resident rights training was completed for 1 of 4 employees (the Administrator) reviewed for annual resident rights training. Findings include: Employee records were reviewed on 2/8/24 at 1:56 p.m. and indicated the following: The Administrator annual resident rights training was not completed.	F 0942	Tag number: F942 I What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; The employee identified during the survey has completed the resident rights in-service. II. How other residents having the potential to be affected by the same deficient practice will be	02/29/2024

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	During an interview with the Administrator, with the Nurse Consultant present, on 2/8/24 at 3:22 p.m., she indicated a lot of the inservices had not "opened" yet. They opened according to the employee's hire date, but the employees should had completed last year's inservices. A current facility policy, dated 10/1/22, titled "Employee Education," provided on the conference room table on 2/8/24 at 3:41 p.m., indicated the following: "...Guidelines: The facility shall provide a Staff Education Plan in accordance with State and Federal regulations...4. The staff education plan shall ensure that education is conducted annually for all facility employees, at a minimum, in the following areas...e. Resident rights...." This citation relates to Complaint IN00425927. 3.1-14(k)(1)		identified and what corrective action(s) will be taken. All residents have the potential to be affected by this alleged deficient practice. III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; Human Resources provide a calendar of when in-services are due to all department heads to monitor timely completion. Human resources will audit in-service completion weekly and provide a report to the Executive director. IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; Executive Director/designee will audit the employee list weekly and will contact each staff member to ensure that each has finished their Resident Rights training by 02/29/2024. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA	

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			Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	
F 0943 SS=D Bldg. 00	483.95(c)(1)-(3) Abuse, Neglect, and Exploitation Training §483.95(c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on- §483.95(c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. §483.95(c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property §483.95(c)(3) Dementia management and resident abuse prevention. Based on interview and record review, the facility failed to ensure required abuse training was completed for 2 of 4 employees reviewed for annual abuse training. (Administrator and LPN 12) Findings include: Employee records were reviewed on 2/8/24 at 1:56 p.m. and indicated the following: The Administrator's annual abuse training was not completed.	F 0943	Tag number: F943 I I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; All employees are now current on their required abuse in-service. II. How other residents having the potential to be affected by the	02/29/2024

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	LPN 12's annual abuse training was not completed. During an interview with the Administrator, with the Nurse Consultant present on 2/8/24 at 3:22 p.m., she indicated a lot of the inservices had not "opened" yet. They opened according to the employee's hire date, but the employees should had completed last year's inservices. A current facility policy, dated 10/1/22 and titled "Employee Education," provided on the conference room table on 2/8/24 at 3:41 p.m., indicated the following: "...Guidelines: The facility shall provide a Staff Education Plan in accordance with State and Federal regulations...4. The staff education plan shall ensure that education is conducted annually for all facility employees, at a minimum, in the following areas...c. Abuse...." This citation relates to Complaint IN00425927.		same deficient practice will be identified and what corrective action(s) will be taken; All residents have the potential to be affected by this alleged deficient practice. III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; Human Resources will provided a calendar of when in-services are due to all department heads to monitor timely completion. Human resources will audit in-service completion weekly and provide a report to the Executive director IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; Executive Director/designee will audit the employee list weekly for compliance. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA	

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			Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	
F 9999 Bldg. 00	3.1-14 PERSONNEL (u) In addition to the required inservice hours in subsection (l), staff who have regular contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months of initial employment, or within thirty (30) days for personnel assigned to the Alzheimer's and dementia special care unit, and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents and to gain understanding of the current standards of care for residents with dementia. This state rule is not met as evidenced by: Based on interview and record review, the facility failed to ensure the required three hours of annual dementia training was completed for 4 of 4 employees reviewed for annual training. (Administrator, LPN 12, CNA 7 and CNA 15) Findings include: Employee records were reviewed on 2/8/24 at 1:56 p.m. and indicated the following: The Administrator's hire date was 10/31/21. The	F 9999	Tag number: F9999 I I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; All employees are now current with their dementia in-services. II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents have the potential to be affected by this alleged deficient practice. III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; Human Resources will provided a calendar of when in-services are due to all department heads to monitor timely completion. Human resources will audit in-service completion weekly and provide a report to the Executive director.	02/29/2024

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	Adminsitrator indicated, on 2/7/24 at 3:30 p.m., that she would provide her training records. She completed two hours of dementia training, on 2/8/24, after the start of the survey. LPN 12's hire date was 8/6/21. The last completed dementia training was 7/1/22. CNA 7's hire date was 1/27/20. She had not completed two hours of the required three hours of annual dementia training. CNA 15's hire date was 2/14/22. She had not completed one hour of the required three hours of annual dementia training. During an interview with the Administrator and with the Nurse Consultant present, on 2/8/24 at 3:22 p.m., she indicated a lot of the inservices had not "opened" yet. They opened according to the employee's hire date, but the employee's should had completed last year's inservices. A current facility policy, dated 10/1/22, titled "Employee Education," provided on the conference room table, on 2/8/24 at 3:41 p.m., indicated the following: "Guidelines: The facility shall provide a Staff Education Plan in accordance with State and Federal regulations...8. The facility will ensure that all employees will have training, as required by the State regarding Dementia, both at within 60 days of hire and annually thereafter...." This citation relates to Complaint IN00425927.		IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; ; Executive Director/designee will audit the employee in-service list weekly for compliance. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	