CENTERS FO	R MEDICARE & MEDIC	CAID SERVICES				OM	IB NO. 0938-039
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155254	, ,	JILDING	onstruction 00	(X3) DATE COMPI 08/30	LETED
	PROVIDER OR SUPPLIEF			5430 V	ADDRESS, CITY, STATE, ZIP COD V US 40 NFIELD, IN 46140		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE COMPLETION DATE	
F 0000	REGULATORT OF	RESCRIBENTIFT INCHINFORMATION		TAU			DATE
Bldg. 00			F 00	000	PLAN OF CORRECTION ON		
	Licensure Survey. Investigation of Co IN00439795, and II	mplaints IN00439061, N00440705.		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	PLAN OF CORRECTION ON BEHALF OF APERION CARE GREENFIELD "This plan of correction constitutes the facility's written credible allegation of compliance. Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or the conclusion set		
	the allegations are of	9061- No deficiencies related to cited.					
	Complaint IN00439 the allegations are of	9795- No deficiencies related to cited.					
	Complaint IN00440 the allegations are of	0705- No deficiencies related to cited.			forth in the Statement of Deficiencies. This plan of		
	Survey dates: Augu	ast 27, 28, 29, and 30, 2024			correction is prepared and/o executed solely because required by the provisions of		
	Facility number: 00				the health and safety code	, ·	
	Provider number: 1 AIM number: 1002				section 1280 and 42 CFR 48 Facility operators reserve		
	Census Bed Type: SNF/NF: 52 Total: 52				litigation rights of the truth of the facts alleged or the conclusion set forth in the Statement of Deficiencies".		
	Census Payor Type Medicare: 5 Medicaid: 43 Other: 4 Total: 52	:					
	These deficiencies accordance with 41	reflect State Findings cited in 0 IAC 16.2-3.1.					
	Quality review com	npleted on September 6, 2024.					

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

Jennifer Adams HFA 09/17/2024

Any defiency statement 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 disclodays 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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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA			ONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	00	COMPL	
		155254	B. WI	NG		08/30/	2024
	PROVIDER OR SUPPLIER N CARE GREENFIE SUMMARY S			STREET ADDRESS, CITY, STATE, ZIP COD 5430 W US 40 GREENFIELD, IN 46140 ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
F 0558 SS=E Bldg. 00	review, the facility is available at the beds reviewed for accomn 21,19, 30, 43, 41, 3. Findings include: 1. Resident 21's recep.m., indicated diagnot limited to, type schizoaffective disonouring an observation at 12:34 p.m., Resident 21's bedfull. Fresh ice water on 8/27/24. During an observation at Resident 21's bedfull. Fresh ice water on 8/27/24. During an observation styrofoam cup was "8/28" written on it. sitting on the bedsice An Admission Miniassessment, dated, 7 was cognitively intaken and indicating to encour 2. Resident 31's received.	on, interview, and record failed to ensure fluids were side for 7 of 7 residents modation of needs. (Residents 1, and 35) ord, reviewed on 8/28/24 at 2:40 noses that included, but were 2 diabetes mellitus, rder, bipolar, and dementia. on and interview on 08/27/24 lent 21 indicated no ice water esident 21 indicated staff used night, now if they wanted emselves. A cup was located side and was less than half thad not been passed, thus far, on on 08/29/24 at 10:26 a.m., a on the bedside table with Another empty cup was let able. mum Data Set (MDS) 1/19/24, indicated Resident 21 let for daily decision making.	F 05	558	What Corrective Action(s) We Be Accomplished For Those Residents Found To Have Be Affected By The Deficient Practice: Residents 21, 19, 30,43,41,31 and 35 did not have any adverse effects related to thi alleged deficient practice. Those residents were provide fluids at their bedsides. How Other Residents Having The Potential To Be Affected By The Same Deficient Practice Will Be Identified Ar What Corrective Action(s) We Be Taken: All other residents have the potential to be affected by the alleged deficient practice. What Measures Will Be Put Into Place and What Systemi Changes Will Be Made To Ensure That The Deficient Practice Does Not Recur: All residents will be provided with fluids at their bedside unless contraindicated, such NPO. Staff were in-serviced of the Hydration policy and procedure on 9/3/24.	een , s ed g and ill is	09/17/2024

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA			NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	00	COMPL	
		155254	B. Wl	NG		08/30/	/2024
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
				5430 W			
APERION	N CARE GREENFIE	=LU		GREEN	IFIELD, IN 46140		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		nic obstructive pulmonary			Will Be Monitored To Ensure		
disease, cerebral infarction, heart failure, and schizophrenia.				The Deficient Practice Will N Recur:	ot		
	semzopmema.			Recur:			
	During an observati	ion on 8/28/24 at 10:47 a.m.,			DON/Designee will monitor fluid		
	Resident 31 did not have any water at the bedside.				at bedside in resident rooms d		
		-			on scheduled workdays times	•	
	•	ion on 8/29/24 at 10:33 am.,			weeks, then 2 times per week		
	Resident 31 had no	cup of water at the bedside.			times 4 weeks, then weekly tir		
					4 weeks. Any negative findin	_	
		ord, reviewed on 8/28/24 at 2:43			will be corrected immediately	У	
		gnoses that included, but were			and forwarded to the		
		myalgia, alcoholic cirrhosis, pulmonary disease, bipolar,			Administrator. A report of	_	
	anxiety, and hepatic				progress will be forwarded to the QAPI committee monthly		
	anxiety, and nepatio	c encephatopathy.			for a minimum of 6 months		
	During an observati	ion and interview on 8/27/24 at			and/or 100% compliance and	ı	
	_	35 had no water at the bedside.			plan will be adjusted	•	
	-	ed, "we rarely ever get fresh ice			accordingly.		
	water and definitely	y not daily".			0,1		
	_	ion on 8/29/24 at 10:33 a.m.,					
	Resident 35 had no	cup of water at the bedside.					
	A Quarterly MDS a	assessment, dated 8/20/24,					
		35 was cognitively intact.					
	marcarea resident.	cognitively intact.					
	4. Resident 41's rec	ord, reviewed on 8/28/24 at 2:38					
		gnoses that included, but were					
		e respiratory failure,					
	encephalopathy, par	raplegia, type 2 diabetes,					
	anemia, and hyperto	ension.					
	Danie 1 1	:					
		ion and interview on 8/28/24 at					
	· ·	at 41 had no water at the cated there was never any					
		ight in the room. Resident 41					
	_	vater in the room was the one					
	to flush out the feed						
		-	1				1

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPI	LETED
		155254	B. W	ING		08/30	/2024
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIEF	R		5430 W			
APERIO	N CARE GREENFI	ELD		GREEN	IFIELD, IN 46140		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY		DATE
	_	ion on 8/29/24 at 10:36 a.m., water at the bedside.					
	During an observat	ion on 8/30/24 at 10:01 a.m.,					
	Resident 41 had no water at the bedside.						
	An Admission MD	S assessment, dated 7/16/24,					
	indicated Resident	41 was cognitively intact.					
	5. Resident 43's rec	ord, reviewed on 8/28/24 at 2:37					
	1 -	gnoses that included, but was					
		iplegia and hemiparesis					
	1	l infarction, acute respiratory					
	failure, aphasia, and	d hypertension.					
	During an observat	ion and interview on 8/27/24 at					
	_	t 43 indicated there was no					
	water at the bedside	e. They hardly had any ice					
	water brought into	their room.					
	During an observat	ion on 8/29/24 at 10:31 a.m.,					
	_	water at the bedside.					
	During an observat	ion on 08/30/24 10:47 a.m.,					
	_	water cup at the bedside.					
		red, "they did come in one time					
		p of fresh water, but no one					
	has been in today".						
	A MDS assessment	t, dated, 8/19/24, indicated					
	Resident 43 was co						
	During an interviev	v on 08/29/24 at 10:37 a.m.,					
	_	Assistant (CNA) 10 indicated					
		d water to the residents in the					
		ended on how busy it was and					
	_	took. If the staff don't pass ice					
		ng, they attempt to get it done					
	after lunch or befor						
	o. The clinical reco	rd for Resident 19 was reviewed	1		I		1

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PRINTED: 09/24/2024 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES						AB NO. 0938-039
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155254	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 08/30/2024	
	PROVIDER OR SUPPLIE		STREET A 5430 W GREEN			
(X4) ID PREFIX	SUMMARY (EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROI	BE	(X5) COMPLETION
TAG		R LSC IDENTIFYING INFORMATION 30 p.m. The medical diagnoses	TAG	DEFICIENCY)		DATE
	indicated Resident	assessment, dated 7/26/2024, 19 was cognitively impaired assistance for daily tasks of				
	Resident 19 was si room. Resident 19	tion on 8/27/2024 at 11:45 a.m., tting in a wheelchair in his had no fluids available in the tic cup was on the floor under				
	Resident 19 was si	tion on 8/29/2024 at 1:46 p.m., tting in a wheelchair is his had no fluids available in his				
		ord for Resident 30 was reviewed :05 a.m. The diagnoses included e.				
	indicated Resident	assessment, dated 7/26/2024, 30 was cognitively impaired t on staff for daily tasks of				
	Resident 30 was si	tion on 8/27/2024 at 1:35 p.m., tting in a wheelchair in her had no fluids available in the				
	Resident 30 was si	tion on 8/29/2024 at 2:20 p.m., tting in a wheelchair in her had no fluids available in her				

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During an interview on 8/27/2024 at 2:05 p.m., CNA 17 indicated staff had no time to pass fluids

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 B. WING			(X3) DATE SURVEY COMPLETED 08/30/2024	
	PROVIDER OR SUPPLIER		5430 V	ADDRESS, CITY, STATE, ZIP COD V US 40 NFIELD, IN 46140	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
F 0584 SS=D Bldg. 00	with meals and if the During an interview Executive Director fluids, but the direct responsible to pass rooms every shift us contraindicated. A policy entitled, "A provided by the Soc 8/30/2024 at 2:10 p fresh cold ice water resident at a minimum 3.1-3(v)(1) 483.10(i)(1)-(7) Safe/Clean/Comfo Environment Based on observation review, the facility is environment for 2 of clean environment. Findings include: 1. Resident 43's clim 8/28/24 at 2:47 p.m. included, but were mellitus, alcoholic of schizophrenia. During an observation, a bedpan, uncovadult diapers were 1	on 8/30/2024 at 1:30 p.m., the indicated all staff can pass a care staff were primarily fresh fluids to residents' nless clinically Water Pass- Hydration", was rial Service Director on m. The policy indicated that would be provided to each am of three times a day.	F 0584	What Corrective Action(s) Wise Accomplished For Those Residents Found To Have Be Affected By The Deficient Practice: Res 43 room has been painter Res 31 and 43s bathroom was deep cleaned and organized. Residents 43 and 31 did not have any adverse effects related to this alleged deficie practice. How Other Residents Having The Potential To Be Affected By The Same Deficient Practice Will Be Identified An What Corrective Action(s) Wi	een ed. s nt

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Event ID:

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STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155254	B. W	NG		08/30/	2024
			<u> </u>	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIEF	8		5430 W			
APERION	N CARE GREENFIE	ELD			IFIELD, IN 46140		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	CY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	i	TAG	DEFICIENCY)		DATE
	frames.				Be Taken:		
	During an interview	v on 8/30/24 at 2:00 p.m., the			All other residents have the		
	Executive Director (ED) indicated she was aware				potential to be affected by th		
		on the wall. The ED indicated			alleged deficient practice.		
		the room kept moving their			unogou demoioni praeties.		
		cuffing] up the paint on the			What Measures Will Be Put		
		ated maintenance had been in			Into Place and What Systemi	ic	
	the room to repaint				Changes Will Be Made To		
	•				Ensure That The Deficient		
	2. Resident 31's clir	nical record, reviewed on			Practice Does Not Recur:		
9/30/24 at 12:46 p.m., indicated diagnoses that							
included, but were not limited to, chronic				Res 43 room has been			
obstructive pulmonary disease, cerebral				painted. Res 31 and 43s			
infarction, heart failure, and hypertension.				bathroom was deep cleaned			
					and organized.		
	_	ion on 8/28/24 at 10:48 a.m.,					
		oom floor had a Styrofoam cup,			Maintenance Director and		
	lid, straw, wash bas	in and toilet paper on it.			housekeeping staff were		
					in-serviced over Quality of		
	-	ion on 08/30/24 at 12:00 p.m.,			Life-Homelike Environment		
		bowl lid was off the toilet and			policy and procedure on 9/3/	24.	
		oom floor. An open toilet			l <u>-</u>		
		sh basin were laying on the			How The Corrective Action(
	floor.				Will Be Monitored To Ensure		
	During an interview	v on 08/30/24 at 02:11 p.m., the			The Deficient Practice Will N	υί	
	-	sident had just taken the toilet			Recur:		
		vas now back in place.			Housekeeping		
	Jowi na on ana it v	vas now back in place.			Supervisor/Designee will		
	A care plan, revised	1 3/7/24, indicated Resident 31			monitor cleanliness and		
	-	th a homelike environment.			Maintenance Director/Design	nee	
	1				will monitor general condition		
	An admission pack	et included resident rights			of 3 different rooms 3 times		
	-	o, on 8/28/24 at 10:45 a.m.,			week times 3 months. Any		
		ave the right to a safe, clean,			negative findings will be		
	-	omelike environment"			corrected immediately and		
					forwarded to the Administrat	tor.	
	3.1-19(f)(5)				A report of progress will be		
			1		forwarded to the OARI		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		l í	(X2) MULTIPLE CONSTRUCTION (X3) DA A. BUILDING 00 CON			SURVEY	
AND PLAN	OF CORRECTION	155254	B. W.		00	08/30/2	
		_		STREET .	ADDRESS, CITY, STATE, ZIP COD	<u></u>	
	PROVIDER OR SUPPLIEI				/ US 40		
APERIO	N CARE GREENFII	ELD 	GREENFIELD, IN 46140				
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	.TE	COMPLETION DATE
	ALGOLINGE OF				committee monthly for minimum of 6 months and/or	r	5.112
					100% compliance and plan w		
					be adjusted accordingly.		
F 0600	483.12(a)(1)						
SS=E	Free from Abuse	and Neglect					
Bldg. 00							
		and record review, the facility idents were free from physical	F 00	500	F600 What corrective Action will b		09/17/2024
		idents were free from physical idents reviewed for abuse.			accomplished for those	e	
	(Residents 2, 13, 3)				residents found to have been	n	
		,			affected by the alleged		
	Findings include:				deficient practice?		
	The clinical reco	ord for Resident 45 was			R esidents 2, 13, 31, 33, and	45	
		4 at 12:15 p.m. Her diagnoses			were not affected by this alleg		
	included, but were	not limited to, dementia and			deficient practice.		
		isorder. She was admitted to					
	the facility on 11/6	/23 from another facility.			Psychosocial assessments		
	TEL 0/1/04 0	1 14' ' D (G ((4.17)G)			completed on 9-17-24 showing	~ I	
	assessment indicate	ly Minimum Data Set (MDS)			signs/symptoms of psychosoc distress.	lal	
	cognitively impaire	-			distress.		
					How will other residents		
	An interview was c	onducted with Family Member			having the same potential to	ı	
		29 p.m. She indicated Resident			affected by the alleged		
		to her current facility from			deficient practice be identifie		
		mily Member 2 received a			and what corrective action w	rill	
		previous facility that Resident			be taken?		
	_	ferred the following day. By the er 2 received the voicemail,			All residents have the		
	,	ready transferred to her current			potential to be affected by th	is	
		5 had behaviors daily. She was			alleged deficient practice.	.	
	· ·	ucinated. Another male					
	resident smacked h	er at the facility about a month			What measures will be put		
	ago.				into place or systemic chang	jes	
					will be made to ensure that t	he	

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Event ID:

82EG11 Facility ID: 000157

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUI	LDING	00	COMPLETED
		155254	B. WIN	NG		08/30/2024
			'	STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>
NAME OF I	PROVIDER OR SUPPLIEF	₹		5430 W		
APERIO	N CARE GREENFI	ELD			IFIELD, IN 46140	
(X4) ID	SHMMADV	STATEMENT OF DEFICIENCIE		ID		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG	`	R LSC IDENTIFYING INFORMATION	1	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
1110		gressive behaviors care plan,			alleged deficient practice do	
	_	licated the goal was for			not occur?	
	·	harm herself, residents, or				
	others.				Staff were in-serviced on	
					Abuse and Abuse prevention	n
	2. The clinical reco	ord for Resident 31 was			and behavior monitoring on	
	reviewed on 8/30/2	4 at 12:00 p.m. Her diagnoses			9-4-24. Staff will receive on	
	included, but were	not limited to, bipolar disorder,			going education on observing	ıg
	depression, psychol	tic disorder, and			residents with increased	
	schizophrenia.				agitation and aggression and	t
					interventions to assist with	
	_	plan, revised 2/29/24, indicated			redirection.	
		directed towards others. The				
goal was for her to not show behaviors of yelling,				4. How will the corrective		
	hitting, and throwir	ig items.			action be monitored to ensur	
	The investigative f	la inta a masidant ta masidant			the alleged deficient practice	,
	_	le into a resident to resident Resident 45 and Resident 31			will not occur?	
		e DON (Director of Nursing)			DON/designee will complete	
	on 8/30/24 at 8:40				staff questions and educatio	
	011 0/30/21 46 0.10	4.111.			on 5 staff members weekly x	
	The file included a	n incident report dated 3/11/24.			months. Any negative finding	
		d, on 3/11/24, Resident 45 was			will be corrected immediately	_
	_	room table drinking her coffee			and forwarded to the	'
	when Resident 31 v	wheeled up behind Resident 45			Administrator. A report of	
	in her wheelchair h	itting Resident 45 with open			progress will be forwarded to	o
		Resident 45 then stood up and			the QA Committee monthly f	or
		inging at each other making			a minimum 6 months and/or	
		ther's face and arms. Head to			100% compliance and plan w	/ill
		re completed on both			be adjusted accordingly	
		dents were placed on one to				
	one supervision.					
	The file in alreded 44.	was undated degrees at a				
		aree, undated, documented ed by the Executive Director				
		ON) Assistant Director of				
		ualified Medication Aide 3, and				
	(CNA) Certified No					
	(Sivi) Solution IV	aronig rububunit i.				
	The undated, docur	nented interview with the				

	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	r í		NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		UILDING	00	COMPL	
		155254	B. W	'ING		08/30	/2024
	PROVIDER OR SUPPLIER			5430 W	NDDRESS, CITY, STATE, ZIP COD US 40 IFIELD, IN 46140		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	BROWING BLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TF.	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		s the nurse on duty. I					
		ted the residents, assessed,					
		dmin [Administrator] present					
	made aware."						
	The undated, docum	nented interview with QMA 3					
		of noise in the hallway. When I					
		er ADON was taking care of					
	_	ted with getting [name of					
		it the dining room. Admin					
		at happened so was made					
	aware."						
	The undated docum	nented interview with CNA 4					
	1	o women swinging at each					
		ped pull them away from each					
	other. Admin and A	ADON present and helped."					
		ord for Resident 2 was reviewed					
		p.m. His diagnoses included,					
	but were not limited	d to, dementia and					
	schizophrenia.						
	The behavior care r	plan, revised 5/25/24, indicated					
	_	gression towards others. The					
	goal was for him to	have a decrease in episodes of					
		elling out towards others with					
	redirection from sta	ff.					
	The in the control of	to the constitute of the state of					
	_	le into a resident to resident Resident 2 and Resident 45					
		e DON (Director of Nursing)					
	on 8/30/24 at 8:40 a						
	The file included ar	n incident report dated 7/1/24.					
	The report indicated	d, on 6/30/24, Resident 2 was					
	_	chair trying to get outside to					
		t 45 was sitting in her					
		ray. Resident 2 attempted to					
	move Resident 45 a	and when Resident 45 asked					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155254		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 08/30/2024	
	PROVIDER OR SUPPLIER		5430 W	ADDRESS, CITY, STATE, ZIP COD / US 40 NFIELD, IN 46140	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	open hand making of to toe assessments v	one, Resident 2 swung with an contact with her left eye. Head were completed on both 2 was placed on one to one			
	interviews conducte	oo undated, documented and by the ED with LPN Nurse) 5 and LPN 6.			
	read, "I was the nur separate the residen Admin [Administra	nented interview with LPN 5 se on duty. I yelled for help to ts, assessed, notified families. tor] just left so I called her to ack and started talking to			
	read, "I was standin the staff for smoke separate and assess	mented interview with LPN 6 g in the dining room, assisting break. I helped [name of LPN 5] the residents. I was standing PN 5] when he called Admin."			
	reviewed on 8/30/24 included, but were i	ord for Resident 13 was 4 at 12:04 p.m. Her diagnoses not limited to, schizoaffective ression, and anxiety.			
	altercation between	le into a resident to resident Resident 13 and Resident 45 e DON (Director of Nursing) a.m.			
	The report indicated in her wheelchair ro she got too close to reacted by swinging contact with the bac	n incident report dated 7/25/24. d, on 7/25/24, Resident 13 was olling down the hallway where Resident 45. Resident 45 g with an open hand making ok of Resident 13's head. Both rated and assessed. Resident			

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	NT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		r ´	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED
		155254	B. WING	_	08/30/2024
NAME OF I	PROVIDER OR SUPPLIEF			T ADDRESS, CITY, STATE, ZIP COD	
ΔΡΕΡΙ∩!	N CARE GREENFIE	=I D		W US 40 ENFIELD, IN 46140	
	Т				
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B)	(X5)
TAG	•	ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	PREFIX TAG	CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	
		ne to one supervision. The			
	_	section indicated both residents			
	were seen by their p	physicians.			
	The file included th	rree, undated, documented			
		ed by the ED with QMA 7, the			
	ADON, and CNA 8	-			
	The undated, docum	nented interview with QMA 7			
		es of Resident 45 and Resident			
		was down getting report so I			
		I didn't assist with anything.			
	Admin [Administra situation."	tor] was present and handling			
	situation.				
		nented interview with the			
		s walking past the MDR [main			
		I saw [name of Resident 45] e of Resident 13.] I separated			
		of admin and staff. Notified			
	_	ector], families, and completed			
	_	ed with 1:1s [one to one			
	supervision]"				
	The undated, docum	nented interview with CNA 8			
	· ·	of noise coming from the			
	· ·	on as I turned the corner the			
	-	there. I helped get [Resident			
	_	g room. Admin was also in the			
	dining room helping	g.			
	5. The clinical reco	ord for Resident 33 was			
		4 at 12:06 p.m. His diagnoses			
		not limited to, traumatic brain			
	injury, bipolar disor	rder, and depression.			
	The 7/29/24 investi	gative file into a resident to			
		between Resident 31 and			
	_	ovided by the Housekeeping			
	Supervisor on 8/30/	24 at 8:55 a.m.	1	1	

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Event ID:

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	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	ľ		NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155254	A. BUILD B. WING	ING	00	COMPL 08/30/	
		100204		_		06/30/	2024
NAME OF F	PROVIDER OR SUPPLIEF	8			DDRESS, CITY, STATE, ZIP COD		
APERIO	N CARE GREENFIE	ELD			FIELD, IN 46140		
(X4) ID		STATEMENT OF DEFICIENCIE	II		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·	CY MUST BE PRECEDED BY FULL		FIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	17	AG	DEFICIENC 17		DATE
	The file included ar	n incident report dated 8/5/24.					
	The report indicated, on 7/29/24, both residents						
	were in the hallway in their wheelchairs. Resident						
	33 was passing by Resident 31 when Resident 31						
	reached over and slapped Resident 33 in the face						
		d. Both residents were					
	immediately separated and assessed. Neurological checks were initiated on Resident 33. The 8/5/24						
		adicated Resident 31 was seen					
	_	d medications were adjusted.					
	oy ner physician an	a mearcarions were adjusted.					
	The file included three, undated, documented						
	interviews conducte	ed by the ED with LPN 6, Staff					
	Member 50, and CN	NA 9.					
	1	nented interview with LPN 6					
		of noise so I can [sic] around witness it but was made aware					
		[Administrator.] I assessed					
	1 -	notifications to families and					
		resent so I didn't report to					
	anyone."	•					
	1	nented interview with Staff					
		was in the dining room when it					
		me of Resident 33] while					
		er got [name of Resident 31.] d the corner and asked what					
	happened and I told						
	happened and I told	1101.					
	The undated, docum	nented interview with CNA 9					
	1	and grabbed [name of Resident					
	, ,	the dining room. Admin came					
	around the corner a	nd assisted with the incident."					
	An interview was c	onducted with the ED on					
	8/30/24 at 9:52 a.m	. She indicated after					
	investigating, she si	ubstantiated resident to					
	resident abuse for a	Il four altercations, as she was					

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	LTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUI	LDING	00	COMPL	
		155254	B. WIN	IG		08/30/	2024
	ROVIDER OR SUPPLIER			5430 W	NDDRESS, CITY, STATE, ZIP COD US 40 FIELD, IN 46140		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE	_	ID			(X5)
PREFIX		CY MUST BE PRECEDED BY FULL	P	REFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	A)	
	present for most of witnessed by staff.	them, and all four of them were					
	provided by the SSI 8/29/24 at 12:23 p.m. the right of our residence of the right of our residence of the right of our residence of the right of our residents abuse, negmisappropriation of residentsAbuse: mental injury or sex resident other than be the willful infliction confinement, intimit resulting physical has a residentPhysical injury on a resident accidental means an attention. Physical a slapping, pinching,	on and Reporting policy was D (Social Services Director) on in. It read, "This facility affirms dents to be free from abuse, in, misappropriation of in of goods and services by int. This facility therefore elect, exploitation, property, and mistreatment of Abuse means any physical or interest and influence of injury, unreasonable dation, or punishment with influence is the infliction of that occurs other than by ind that requires medical induse includes hitting, kicking, and controlling or poral punishment."					
F 0625 SS=D Bldg. 00	483.15(d)(1)(2) Notice of Bed Hold	d Policy Before/Upon Trnsfr					
J	failed to maintain de	and record review, the facility ocumentation Resident 5's provided with a bed hold ident reviewed for	F 062	25	F625 What corrective Action will be accomplished for those residents found to have been affected by the alleged deficient practice?		09/17/2024
	Findings include:				Res 5 was not affected by the alleged deficient practice. SS	D	
	The clinical record	for Resident 5 was reviewed on			went over the bed hold polic	y	

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	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	r í		NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	00	COMPLE	
		155254	B. WI	NG		08/30/2	2024
	PROVIDER OR SUPPLIER			5430 W	NDDRESS, CITY, STATE, ZIP COD US 40 IFIELD, IN 46140		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DROVIDER'S DLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	8/29/24 at 2:34 p.m stroke.	. The diagnoses included			with resident 5 on 9-12-24.		
	A Quarterly Minima assessment, dated 6 was cognitively into The census flowshe therapeutic leave from During an interview Resident 5 indicated hold policy was and paperwork prior to gaperwork prior to ga	et for Resident 5 indicated a om 7/22/24 to 7/26/24. If on 8/30/24 at 1:45 p.m., It he did not know what a bed a did not receive any going to the hospital in July of the one of the folicy for Resident 5's July expectation was nursing staff and hold policy at the time of the ent or their representative. If Bed Hold Policy Notice of the one of the on			How will other residents have the same potential to affected by the alleged deficient practice be identified and who corrective action will be take All residents have the potent to be affected by this alleged deficient practice. How will other residents have the same potential to affecte by the alleged deficient practice be identified and who corrective action will be take An audit was completed on residents who transferred to the hospital. Nursing staff and SSD were in-serviced on 9-12-24 on the bed hold policy. How will the corrective action be monitored to ensure the alleged deficient practice will not occur? SSD/designee will audit all residents who are transferred to the hospital weekly x 4 weeks, then biweekly x 2 months. Any negative finding will be corrected immediately and forwarded to the Administrator. A report of progress will be forwarded to the QA Committee monthly fa minimum 6 months and/or 100% compliance and plan who be adjusted accordingly.	d at en? tial d ing d at en? d ing d in at en? d ing d in at en? d in at en?	

AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155254 NAME OF PROVIDER OR SUPPLIER		X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP COD 5430 W US 40				
APERIO	N CARE GREENFIE	ELD			NFIELD, IN 46140	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
F 0641 SS=D Bldg. 00	failed to accurately (MDS) information from MDS accuracy Findings include: 1. The clinical record on 8/29/24 at 2:34 phipolar disorder. An Admission MDS indicated that Resident information information in the second indicated that the second indicated in the second information in the second indicated in the second indicated in the second information in the second information in the second indicated in the second in th	and record review, the facility encode Minimum Data Set for 2 of 19 residents reviewed y. (Resident 5 and Resident 19) and for Resident 5 was reviewed o.m. The diagnoses included S assessment, dated 2/1/24, lent 5 did not have a PASARR ening and Resident Review)	F 06	541	What Corrective Action(s) Water Beach By The Deficient Practice: Residents 5 and 19 were not affected by this alleged deficient practice. MDS for resident 5 dated 2/1/24 has been modified to reflect PASARR level II and MDS for resident 19 dated 7/26/24 has been modified to show correspond to the process of the process o	een r s
	Resident 5 had a ser need specialized ser During an interview Social Services Dire a serious mental illr II was the one dated 2. The clinical record on 8/30/2024 at 1:30 included chronic ob A Quarterly MDS a indicated Resident 1 six months or less be	on 8/30/24 at 11:45 a.m., the ector indicated Resident 5 had ness and the most current Level			How Other Residents Havin The Potential To Be Affected By The Same Deficient Practice Will Be Identified Al What Corrective Action(s) W Be Taken: All other residents have the potential to be affected by th alleged deficient practice. What Measures Will Be Put Into Place and What System Changes Will Be Made To Ensure That The Deficient Practice Does Not Recur: MDS audit was completed	nd Vill

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTII A. BUILDI	PLE CONSTRUCTION NG 00	(X3) DATE SURVEY COMPLETED
		155254	B. WING		08/30/2024
APERIO	PROVIDER OR SUPPLIE	ELD	54 GF	REET ADDRESS, CITY, STATE, ZIP COD I30 W US 40 REENFIELD, IN 46140	
(X4) ID PREFIX TAG	(EACH DEFICIENT REGULATORY O	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREF TA	FIX PROVIDER'S PLAN OF CORRECT FIX (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPI AG DEFICIENCY)	TION (X5) ILD BE COMPLETION ROPRIATE DATE
	provided, on 8/30/2 Executive Director with a life expectar disease runs its pro During an interview MDS Nurse indica assessments for Re coded incorrectly of A policy entitled, " and Care Planning the Social Services The policy indicate	erminal illness for Resident 19 24 at 10:45 a.m., by the indicated a terminal diagnosis ney of six months or less if the ejected course. w, on 8/30/24 at 12:45 p.m., the ted the aforementioned sident 5 and Resident 19 were lue to oversight. Resident MDS Assessment Standard", was provided by Director on 8/30/24 at 2:10 p.m. ed all assessments are to be und accurately for the Resident		MDS Coordinator, and were in-serviced on 9/3/MDS policy and procedu focus on checking accu assessment before sign responsible MDS section. How The Corrective Act Will Be Monitored To Enthe Deficient Practice Will monitor assessment accuracy quarterly with MDS assessment prior to submitting the MDS on-Any negative findings we corrected immediately a forwarded to the Adminial A report of progress will forwarded to the QA Committee monthly for minimum 6 months and 100% compliance and pube adjusted accordingly	24 over ure with uracy of uing their n. tion(s) nsure Vill Not gnee t each to going. rill be und istrator. I be a //or lan will
F 0645 SS=D Bldg. 00		ing for MD & ID and record review, the facility sident 11 had a completed	F 0645	What Corrective Action(Be Accomplished For Ti Residents Found To Hav	hose
		ening and Resident Review		Affected By The Deficien	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 08/30/2024 155254 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 5430 W US 40 APERION CARE GREENFIELD GREENFIELD, IN 46140 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE (PASARR) prior to admission to the facility for 1 Practice: of 3 residents reviewed for PASARR. Resident 11 did not have any adverse effects related to this Findings include: alleged deficient practice. Level II PASARR was The clinical record for Resident 11 was reviewed completed for resident 11 on on 8/30/24 at 12:15 p.m. The diagnoses included 9/12/24 schizophrenia. **How Other Residents Having** An Admission Minimum Data Set (MDS) The Potential To Be Affected assessment, dated 2/1/24, indicated Resident 11 By The Same Deficient did not have a PASARR Level II. Practice Will Be Identified And What Corrective Action(s) Will Per the Indiana State Department of Family and Be Taken: Social Services Administration, all applicants to Medicaid-certified nursing facilities in Indiana are All other residents have the entered in the state's web-based PASARR system, potential to be affected by this and a Level I screen is completed to initiate the alleged deficient practice. PASARR process. If indicated, a PASARR Level II evaluation is performed to identify the **What Measures Will Be Put** specialized needs of individuals with mental Into Place and What Systemic illness (MI), intellectual or developmental **Changes Will Be Made To** disability ID/DD, or both (MI/ID/DD). **Ensure That The Deficient** Practice Does Not Recur: A PASARR Level I for Resident 11, dated 1/24/19, indicated that Resident 11 needed an on-site Level An audit was completed on all II review. residents currently residing at the facility for Level I and During an interview on 8/30/24 at 12:55 p.m., the Level IIs. Social Service Director (SSD) indicated the facility did not have documentation for a Level II SSD was in-serviced on 9/3/24 completed for Resident 11 after 1/24/2019. The over Level I and Level II SSD indicated the facility received an influx of PASARR policy and procedure. residents around the time Resident 11 admitted SSD will be responsible for and that the Level II was not completed due to completing Level I and Level II oversight. PASARR's for current residents and all new admissions. A policy entitled, "Preadmission Screening and Annual Resident Review (PASARR)", was How The Corrective Action(s) Will

provided by the Director of Nursing on 8/30/24 at

Be Monitored To Ensure The

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 B. WING		(X3) DATE SURVEY COMPLETED 08/30/2024					
	ROVIDER OR SUPPLIER		·	5430 W	NDDRESS, CITY, STATE, ZIP COD US 40 IFIELD, IN 46140		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
F 0657	participate in or con all potential admissi sourceBased on t determined to meet will not admit and i the potential admissi	y indicated, " The facility will inpleted the Level I screen for ions regardless of payer he Level I, if an individual is the above criterion, the facility individual, the facility will refer sion to the State PASARR Level II screening process"			Deficient Practice Will Not Reco	cur:	
SS=D Bldg. 00	Care Plan Timing Based on interview failed to hold regular meetings for 1 of 2 planning. (Resident Findings include: The clinical record on 8/28/24 at 12:15 but were not limited depressive disorder facility, on 11/6/23, The 11/6/23 nursing admit from [name of facility via fa	and Revision and record review, the facility arly scheduled care plan residents reviewed for care t 45) for Resident 45 was reviewed p.m. Her diagnoses included, I to, dementia and major. She was admitted to the from another facility. g note read, "Resident is a new of previous facility,] came to the van. Resident is alert to name lace where she is and time of	F 06	57	What corrective Action will be accomplished for those residents found to have been affected by the alleged deficient practice? Resident 45 had a care plan meeting on 9-12-24 was invite but declined to attend. How wo ther residents having the same potential to affected by the alleged deficient practice be identified and what corrective action will be take All other residents have the potential to be affected by the alleged deficient practice. When measures will be put into pla or systemic changes will be made to ensure that the alleged deficient practice do not occur? An audit was completed on care plan invitations/meetings SSD was in-serviced on 9/4/24 the nee to provide and invite residents/family to care plan	ed rill n? is at ce	09/17/2024

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09/24/2024 PRINTED: FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 08/30/2024 155254 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 5430 W US 40 APERION CARE GREENFIELD GREENFIELD, IN 46140 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE another facility. Family Member 2 received a meetings.MDS/DON/ADON/SSD voicemail from the previous facility that Resident was in-serviced on 9/4/24 over 45 was being transferred the following day. By the the comprehensive Care plan time Family Member 2 received the voicemail, policy to include the Resident 45 was already transferred to her current importance of documentation facility. Family Member 2 received several phone of meeting within residents calls about missed appointments from a local charts.4. How will the hospital provider regarding missed oncology, corrective action be monitored optometry, and diabetic clinic appointments. She to ensure the alleged deficient hadn't had any scheduled care plan meetings with practice will not occur? the current facility to discuss these things. SSD/designee will audit up to 5 care plan invitations and The electronic health record (EHR) indicated documentation of care plan Resident 45 had a, 11/14/23, Admission MDS meetings weekly x 3 months. assessment and, 5/1/24, Quarterly MDS Any negative findings will be assessment, but no corresponding care plan corrected immediately and forwarded to the Administrator. meetings were found. A report of progress will be The 4/29/24, 3:12 p.m. care plan invite note forwarded to the QA indicated there would be a care plan meeting held, Committee monthly for a on 5/23/24, and that Family Member 2 was minimum 6 months and/or planning on attending. 100% compliance and plan will be adjusted accordingly. There was no information in the clinical record indicating the, 5/23/24, care plan meeting ever took place. An interview was conducted with the Social Services Director (SSD) in the presence of the ADON (Assistant Director of Nursing) on 8/30/24 at 11:08 a.m. The SSD indicated they held care plan meetings for residents quarterly. The meetings were documented in the EHR under a care plan meeting note. He was out of the facility in May 2024, so he couldn't speak as to whether the, 5/23/24, care plan meeting was held. He reviewed Resident 45's clinical record and indicated he did not see actual verification the, 5/23/24, care plan meeting was held, and there was no verification of a, November 2023, care plan

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/24/2024 FORM APPROVED OMB NO. 0938-039

	OF CORRECTION	IDENTIFICATION NUMBER 155254	BER A. BUILDING <u>00</u> COMPL		COMPLETED 08/30/2024	
NAME OF F	PROVIDER OR SUPPLIER			ET ADDRESS, CITY, STATE, ZIP COD O W US 40		
APERIO	N CARE GREENFIE	ELD	GRE	EENFIELD, IN 46140		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	COMPI	
	a meeting after Resi to the facility. He'd the phone previousl of any missed appoi The Comprehensive provided by the (DO	e Care Plan policy was DN) Director of Nursing on				
	care plan must beinterdisciplinary teal limited toTo the eparticipation of the representative(s). A included in a reside participation of the representative is det the development of resident and/or resident and/or resident to review the interdisciplinary teat telephone or video cleast quarterly. As a	m that includes but is not xtent practicable, the resident and the resident's n explanation should be nt's medical record if the resident and their resident termined not practicable for the resident's care planThe dent representative shall be e plan of care with the m either in person, via conference (if available) at				
	an initial meeting w representative withi review the baseline or revisions as indic input of the resident	rith the resident and/or resident in 5 days of admission to plan of care and make updates rated based on feedback and a and/or representative prior to the comprehensive care plan."				
F 0679 SS=D Bldg. 00	483.24(c)(1) Activities Meet Into	erest/Needs Each Resident	F 0679	What Corrective Action(s) W	/ill 09/17	7/2024
	review, the facility	on, interview, and record failed to follow scheduled or provide outside activities for		Be Accomplished For Those Residents Found To Have B Affected By The Deficient		

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	URVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLE	ETED
		155254	B. W	ING		08/30/2	2024
				CERTE	ADDRESS STEV STATE STR SOD		
NAME OF F	PROVIDER OR SUPPLIER	t			ADDRESS, CITY, STATE, ZIP COD		
4050101	LOADE ODEENEU	-1.5		5430 W			
APERIOI	N CARE GREENFIE	בנט		GKEEN	NFIELD, IN 46140		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	ii C	DATE
	3 of 3 residents revi	iewed for activities. (Resident			Practice:		
	34, Resident 41, and	d Resident 35).			Residents 34,35, and 41 were	9	
					not affected by this alleged		
	Findings include:				deficient practice. Residents	;	
					will have an ongoing activity		
	1. Resident 35's rec	ord, reviewed on 8/28/24 at 2:43			program that meets their		
	p.m., indicated Resident 35 had diagnoses that				needs. Psychosocial		
	included, but were not limited to, fibromyalgia,				assessments were complete	d	
	type 2 diabetes, alco	oholic cirrhosis, chronic			on 9-17-24 showing no		
	obstructive pulmon	ary disease, and alcohol			signs/symptoms of psychos	ocial	
	abuse.				distress. How Other Residen		
					Having The Potential To Be		
	A Quarterly Minimum Data Set (MDS) assessment				Affected By The Same		
	for Resident 35, dated 8/20/24, indicated he was				Deficient Practice Will Be		
	cognitively intact for	or daily decision making.			Identified And What Correcti	ve	
					Action(s) Will Be Taken:		
	During an interview	on 8/27/24 at 1:16 p.m.,			All residents have the potent	tial	
	Resident 35 indicate	ed that the activities director			to be affected by this alleged	i	
	did not offer a varie	ety of activities. "We were			deficient practice		
	supposed to play ca	rds one day, which it was on			What Measures Will Be Put I	nto	
	the activities calend	lar, but no one had any cards,			Place and What Systemic		
	so we couldn't play	". Resident 35 had requested			Changes Will Be Made To		
	to go on outings wi	th the facility, but the facility			Ensure That The Deficient		
	l '	e they do not have enough			Practice Does Not		
	transportation for al	ll the residents.			Recur:Activity Director and		
					activity staff were in-service	d	
		nical record, reviewed on			on 9/4/24 over Activities poli	су	
	1	., indicated diagnoses that			and procedure.Activities		
		not limited to, acute respiratory			director will ensure that the		
		athy, major depressive			monthly calendar is being		
	disorder, and hyper	tension.			followed and outside activitie	es	
					has been added to the		
		S assessment, dated 7/16/24,			calendar. How The Correctiv	· I	
		41 was cognitively intact for			Action(s) Will Be Monitored		
	daily decision maki	ng.			Ensure The Deficient Practic	e	
					Will Not Recur:Activity		
	_	on 8/28/24 at 10:30 a.m.,			Director/Designee will monit		
		ed he wanted to leave the			activity program calendar on		
		but they did not provide it.			scheduled workdays weekly		
	Resident 41 indicate	ed they do not get to go	1		times 4 weeks, then every 2		

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	IULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		UILDING	00	COMPLETED
		155254	B. W	'ING		08/30/2024
NAME OF D	DOWNER OF CURRINE			STREET A	ADDRESS, CITY, STATE, ZIP COD	
NAME OF P	PROVIDER OR SUPPLIER	C		5430 W		
APERION	N CARE GREENFIE	ELD		GREEN	IFIELD, IN 46140	
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG		DATE
	anywhere, and it wa	as upsetting to nim.			weeks times 2 months. Any	
	Resident 41 had a care plan, dated 2/3/24, and indicated he enjoyed anything outdoors and enjoyed going outside when the weather was nice.				negative findings will be corrected immediately and	
					forwarded to the Administra	tor
					A report of progress will be	.01.
					forwarded to the QA	
					Committee monthly for a	
	During an interview	During an interview on 8/30/24 at 10:52 a.m., the			minimum 6 months and/or	
	Activities Director (AD) indicated the facility had				100% compliance and plan v	/ill
	not been able to lea	ve or go on outings because			be adjusted accordingly.	
	they only had a sma	all van that held three to four				
	people and one whe	eelchair. The AD indicated the				
		n out in the community since				
	-	AD indicated the residents				
	can go outside durir	_				
		ord for Resident 34 was				
		4 at 1:00 p.m. His diagnoses				
		not limited to, hemiplegia and				
	-	al vascular accident, and				
	1/25/22.	as admitted to the facility on				
	1/23/22.					
	The August 2024 A	ctivity Calendar was posted				
	-	allway outside of the dining				
		on 8/28/24 at 11:00 a.m. Daily				
		duled and Church with (name				
	of volunteer) was so	cheduled for 8/28/24 at 11:15				
	a.m.					
	On observation of	esidents, including Resident				
		ng room was made on 8/28/24				
		11:15 a.m. There was no Daily				
		h with (volunteer name)				
		The television was playing a				
	,	ork, but none of the residents,				
		34, were watching. There was				
	-	y occurring in place of the				
		sident 34 was sitting at a table.				
		passed by staff, but no				
	activities were occu	· -				

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE C A. BUILDING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED
		155254	B. WING		08/30/2024
	PROVIDER OR SUPPLIER		5430 V	ADDRESS, CITY, STATE, ZIP COD V US 40 NFIELD, IN 46140	
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIADEFICIENCY)	
TAG	The 8/13/24 Significindicated he was considered he was considered his room on 8/28/24 didn't really do group except bingo twice what the "Daily Christhe August 2024 act was. The Church act today was a volunted didn't come today. The August 2024 At the wall in the hallwindicated manicures 2:30 p.m. An observation of the 8/29/24 at 2:38 p.m. receiving a manicure ten other residents sono other activity, moccurring. The televanews network, but rewatching, and it was to be heard through. An interview and of with Resident 34 in p.m. He was watching activities outside of fishing activity back was the last time the activities outside of fishing activities outside of activities outside of fishing activity.	conducted with Resident 34 in at 1:03 p.m. He indicated they up activities in the facility, a week. He was unaware of conicle" activity, referenced on tivity calendar daily, actually tivity, referenced for 11:15 a.m. ter activity, but the volunteer ctivity Calendar, posted on vay outside of the dining room, a was scheduled for 8/29/24 at the dining room was made on at the by activity staff. There were ditting in the dining room, with usic, art project, or anything vision was playing a national mone of the residents were as not turned up loud enough out the dining room. There was conducted this room on 8/29/24 at 2:42 ang television. He indicated he ong manicures. As far as the facility, there was a can may or June 2024, but that each of the facility to attend an ike for the facility to have more	TAG	DEFICIENCE	DATE

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155254	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 08/30/2024
	PROVIDER OR SUPPLIEF		5430 V	ADDRESS, CITY, STATE, ZIP COD V US 40 NFIELD, IN 46140	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
me	did not reference hi from the facility. It outdoors to get fres from the facility. The August 2024 A the wall in the hally did not include any	s preference for activities away referenced inviting him to go h air, but not activities away ctivity Calendar, posted on way outside of the dining room, activities away from the			
	the DON (Director a.m. It read, "Purpo program of activities residents' interests a highest practicable psychosocial well-be Activity Director, to Identify and involve program of activities his or her interests a 4-7 organized activ. The program of activities that allows thee action implement, and evaluand involvement in	ram policy was provided by of Nursing) on 8/30/24 at 8:40 se: To provide an ongoing as designed to appeal to the and to enhance his or her level of physical, mental, and being. Guidelines: The rained staff, or volunteer will: 1. Se each resident in an ongoing as that is designed to appeal to and needs3. A minimum of tities will be scheduled daily7. Existites will include a system sixty staff to develop, luate the resident's interests the activities provided and gramming as needed in order of the residents."			
	3.1-33(a) 3.1-33(b)(3)				
F 0684 SS=D Bldg. 00	483.25 Quality of Care				
-	review, the facility a skin impairment (observation, and record failed to date a dry dressing to Resident 1) and failed to sment as care planned	F 0684	What Corrective Action(s) W Be Accomplished For Those Residents Found To Have B Affected By The Deficient Practice:	е

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155254	B. W	NG		08/30/	2024
			<u> </u>	STREET /	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	8		5430 W			
ΔDEDI∩N	N CARE GREENFIE	=I D			NFIELD, IN 46140		
AFERIO	V CARE GREENFIE			GINEEN			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	CROSS-REFERENCED TO THE APPRO		CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	` ′	of 2 residents reviewed for skin			Residents 1 and 34 were not		
	impairments.				affected by this alleged		
					deficient practice. Resident	1	
	Findings include:				dressing was changed and		
					dated. Skin assessment was	i	
		rd for Resident 1 was revied on			completed on resident 34		
		. The medical diagnoses					
	included schizophre	enia.			How Other Residents Having	_	
					The Potential To Be Affected	I	
	A Quarterly Minimum Data Set assessment, dated				By The Same Deficient	_	
	8/15/24, indicated that Resident 1 was cognitively				Practice Will Be Identified Ar		
	impaired. Resident 1 needed minimal to substantial				What Corrective Action(s) W	'ill	
	assistance for activities of daily living and was at				Be Taken:		
	risk for developing	skin alternations.					
		1 1 1 1 2 2 2 2 4 2 1 1 1 1			l		
		ent, dated 8/20/24, indicated			All residents have the potent		
	that Resident 1 was	at high risk of skin			to be affected by this alleged	d	
	alternations.				deficient practice		
	A 114'				What Measures Will Be Put I	nto	
		n, dated 8/28/24, indicated			Place and What Systemic		
		n-pressure wound to the scalp thickness from a fall.			Changes Will Be Made To		
		he wound were 3 centimeters			Ensure That The Deficient		
	(cm) x 2 cm x "Not				Practice Does Not Recur:		
	(cm) x 2 cm x Not	ivicasulaule .			An audit was completed on		
	Δ skin care nlan ra	vised 8/28/24, indicated			residents receiving wound		
		brasion to the forehead. An			dressing. An audit was		
		ed to provide treatment as			completed on weekly skin		
	ordered.	ea to provide treatment as			assessments to ensure		
	2.46.64.				dressings were dated.		
	A physician order	dated 8/28/24, indicated to			a. coomigo word dated.		
	1 * *	ent 1's right forehead with a			Licensed nurses were		
	dressing daily.	0 			in-serviced on 9/4/24 over Th	ne	
					skin Condition assessments		
	During an observati	ion, on 8/28/24 at 1:55 p.m.,			monitoring policy to include		
	_	nite dry dressing on the right			weekly skin assessments an		
		I. The dressing did not indicate			dating dressings.		
		als of the staff member which					
	had applied the dres						
	11						

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155254		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/30/2024		
	PROVIDER OR SUPPLIER			5430 W	ADDRESS, CITY, STATE, ZIP COD 'US 40 IFIELD, IN 46140		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
Me	During an observat Resident 1 was in the 1 had a white dry deforehead. The dress time, or initials of the applied the dressing	ion, on 8/29/24 at 12: 20 p.m., he main dining room. Resident ressing on the right side of the sing did not indicate a date, he staff member which had 3.		1740	How The Corrective Action(s Will Be Monitored To Ensure The Deficient Practice Will N Recur: ADON/Designee will monitor wound dressings and 5	ot	BATE
	Resident 1 was layi white dry dressing forehead. The dress time, or initials of s dressing did not con the staff member w LPN 13 stated that dressing" and did n	ion, on 8/29/24 at 2:00 p.m., ng in bed. Resident 1 had a on the right side of the sing did not indicate a date, staff. LPN 13 verified that the ntain date, time, or initials of hich had applied the dressing. she would "change the ot know when it was last			residents skin assessments weekly x 4 weeks, then every weeks for 2 months. Any negative findings will be corrected immediately and forwarded to the Administrat A report of progress will be forwarded to the QA Committee monthly for a		
	reviewed on 8/24/2 included, but were hemiparesis, cerebr	ord for Resident 34 was 4 at 1:00 p.m. His diagnoses not limited to, hemiplegia and al vascular accident, and as admitted to the facility on			minimum 6 months and/or 100% compliance and plan we be adjusted accordingly.	rill	
	An interview and o with Resident 34 in p.m. He indicated, over my arms," for say it's from blood	bservation was conducted this room on 8/28/24 at 1:14 have these dark spots all the past three weeks. "They thinners." Resident 34 had dark ts of various shapes covering					
	Clopidogrel Bisulfa to prevent heart atta	ers indicated for one tablet of ate (antiplatelet medication used acks and strokes) 75 milligrams tered one time a day for stroke,					

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/24/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155254		l í	JILDING	nstruction 00	(X3) DATE COMPL 08/30/	ETED	
	PROVIDER OR SUPPLIEF			5430 W	DDRESS, CITY, STATE, ZIP COD US 40 FIELD, IN 46140		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	The 8/7/24 antiplate an intervention was Report abnormalitie 8/7/24.	elet therapy care plan indicated , "Daily skin inspection. es to the nurse," initiated					
	skin assessment wa August 2024. It was bruising to his abdo arms. There were n	th record (EHR) indicated one s completed thus far in s dated 8/6/24 and referenced omen. It did not reference his o subsequent skin gust 2024 in the EHR.					
	(Director of Nursin indicated skin asses weekly and on show should be documen assessments tab. The 34's EHR at this tinthe, 8/6/24, skin asses who was responsible inspections reference therapy care plan, but the same of th	onducted with the DON g) on 8/29/24 at 10:27 a.m. She assments were completed wer days. The assessments ted in the EHR under the the DON reviewed Resident the and indicated she only saw the sessment. She was unaware the for the daily skin the daily skin the daily skin the daily skin the daily should also be the EHR. She would look further					
	8/29/24 at 2:05 p.m verification of any of Resident 34 in Aug	onducted with the DON on . She indicated she did not have other skin assessments for ust 2024 beyond the, 8/6/24, werification of any daily skin e planned.					
	policy was provided 8:40 a.m. It read, "I guidelines for asses	Assessment & Monitoring d by the DON on 8/30/24 at Purpose: To establish sing, monitoring and esence of skin breakdown,					

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/24/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER) 155254		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 08/30/2024			
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 5430 W US 40 GREENFIELD, IN 46140				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
	conditions and assurimplemented. Guid conditions (bruises/lacerations, rashes, etc.) will be assesse signs of complication weeklyResidents skin assessment by assessment will be in the resident chart whon-pressure skin colicensed nurse. Each skin breakdown dain assigned bath day bhost Assistant.) Changes the charge nurse who assessment Woun	identified will have a weekly a licensed nurse. A wound nitiated and documented in then pressure and/or other conditions are identified by a resident will be observed for ly during care and on the y the CNA (Certified Nursing shall be promptly reported to so will perform the detailed d Assessment/Measurement: the are applied to pressure counds, lesions or incisions are of the licensed nurse who edure. Dressing will be acement, cleanliness, and					
F 0685 SS=D Bldg. 00	483.25(a)(1)(2) Treatment/Device:	s to Maintain Hearing/Vision					
	review, the facility services were provide consented to receive	on, interview, and record failed to ensure optometry ded timely to a resident who e optometry services for 1 of 3 for vision or hearing services.	F 0685	What Corrective Action(s) W Be Accomplished For Those Residents Found To Have Be Affected By The Deficient Practice: Resident 34 will be seen by the optometrist on 9/24/2024 How Other Residents Having The Potential To Be Affected	een		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED 155254 B. WING 08/30/2024 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 5430 W US 40 APERION CARE GREENFIELD GREENFIELD, IN 46140 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE The clinical record for Resident 34 was reviewed By The Same Deficient on 8/28/24 at 1:00 p.m. His diagnoses included, **Practice Will Be Identified And** but were not limited to, hemiplegia and What Corrective Action(s) Will hemiparesis, major depressive disorder, and Be Taken: hypertension. He was admitted to the facility on 1/25/22. All residents have the potential The 2/9/22 ancillary services care plan, revised to be affected by this alleged 7/15/24, indicated he consented to receive deficient practice optometry services through the facility's What Measures Will Be Put Into optometry provider with interventions for him to Place and What Systemic be seen by the appropriate provider to ensure any **Changes Will Be Made To** issue was resolved. **Ensure That The Deficient Practice Does Not Recur:** The 10/30/22 physician's order indicated he may be seen by the optometrist, as needed. An audit of optometrist appointments was conducted The 8/12/24 Ancillary Services Assessment form to ensure timely service for indicated Resident 34 needed assistance with Optometry for any resident that corrective lenses. consented The 8/13/24 Significant Change Minimum Data Set The social worker was assessment indicated he was cognitively intact. in-serviced on the provision and coordination of ancillary An observation and interview were conducted services including optometry with Resident 34 in his room on 8/28/24 at 1:10 services on 9/12/24 p.m. He indicated he currently wore reading glasses, but used to wear regular glasses, and thought he needed to wear regular glasses now. Resident 34 was not wearing any glasses during **How The Corrective Action(s)** the interview. Will Be Monitored To Ensure The Deficient Practice Will Not There were no optometry consultations in Recur: Resident 34's clinical record. SSD/Designee will monitor 5 An interview was conducted with the SSD (Social residents in need of optometrist Services Director) on 8/29/24 at 10:33 a.m. The appointments weekly x 4 SSD indicated they'd worked at the facility since weeks, then every 2 weeks for November 2023. The facility used a specific 2 months. Any negative provider for optometry services. The optometry findings will be corrected

	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155254	(X2) MULTIPLE C A. BUILDING B. WING	OO	(X3) DATE SURVEY COMPLETED 08/30/2024		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 5430 W US 40 GREENFIELD, IN 46140				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI- DEFICIENCY)	(X5) COMPLETION DATE		
	appointments for re provider remained i them know when th facility. At each MI reach out to their or resident needed services was in the facility of not seen at that visit upcoming optometr on it. The SSD revierecord at this time at that Resident 34 had in the facility, at least the The On-Site Health provided by the SSI read, "It is the policing residents in arranging needed per resident Facility will make at	onsent forms and scheduled sidents. The optometry in touch with the SSD to let ey would be coming to the OS assessment, the SSD would be tometry provider, if the vices. The optometry provider in 8/19/24, but Resident 34 was in the SSD reviewed the ylist, but Resident 34 was not ewed Resident 34's clinical and indicated he did not see did received optometry services est since he'd worked there. Care Services policy was D on 8/29/24 at 12:23 p.m. It yof the facility to assisting health services on site as request. Standards: 1) appointments for ancillary did by resident. 2) On-Sitec) Optometry."		immediately and forwarded the Administrator. A report of progress will be forwarded to the QA Committee monthly a minimum 6 months and/or 100% compliance and plan to be adjusted accordingly.	of o for		
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervis	ion/Devices					
-	Based on interview, review, the facility smoking assessmen for smoking safety. Findings include: The clinical record	observation, and record failed to complete quarterly ts for 1 of 1 resident reviewed (Resident 23) for Resident 23 was reviewed o.m. The diagnoses included	F 0689	What Corrective Action(s) Water Be Accomplished For Those Residents Found To Have Be Affected By The Deficient Practice: Resident 23 was not affected this alleged deficient practice Smoking assessment was completed on resident 23 or 9-12-24	een d by ce.		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	COMPLETED	
		155254	B. W	B. WING 08/30/2024		
				CTDEET /	ADDRESS, CITY, STATE, ZIP COD	
NAME OF F	ROVIDER OR SUPPLIER	2		5430 W		
ADEDIO	N CARE GREENFIE	ELD.			IFIELD, IN 46140	
APERIO	N CARE GREENFIE			GREEN	IFIELD, IN 40140	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE
				How Other Residents Havin	q	
	An Annual Minimu	m Data Set assessment, dated			The Potential To Be Affected	<u> </u>
		Resident 23 was cognitively			By The Same Deficient	
	intact and utilized to	- -			Practice Will Be Identified An	nd
	maet and amized to	osacco products.			What Corrective Action(s) Wi	
	A smoking care pla	n, revised 12/5/23, indicated			Be Taken:	""
		rigarette smoker with an			Do Tunon.	
		king assessment upon			All residents have the	
	admission, quarterly	-			potential to be affected by th	ie
	dannosion, quarteri	y una as needed.			alleged deficient practice.	13
	During an interview	on 8/30/24 at 2:15 n m the			aneged denotetit practice.	
	During an interview on 8/30/24 at 2:15 p.m., the Executive Director indicated the staff could not				What Measures Will Be Put	
locate the quarterly smoking assessment for						
	Resident 23 for the last year. Activities and social				Into Place and What Systemi	
					Changes Will Be Made To	
	services were to split the duty of completing smoking assessments. A policy entitled, "Smoking Safety", was provided				Ensure That The Deficient	
					Practice Does Not Recur:	
					Constring an accomment availt	
					Smoking assessment audit	
	-	ce Director on 8/30/24 at 8:40			was completed	
		icated smoking assessment will				
	-	time of admission, quarterly,			Nursing staff, activities	
	and as needed.				director, and SSD were	
	2.1.45(.)(2)				in-serviced on 9/4/24 on the	_
	3.1-45(a)(2)				smoking safety policy which	is
					to be completed upon	
					admission, quarterly, and as	
					needed.	
					How The Corrective Action(s	•
					Will Be Monitored To Ensure	
					The Deficient Practice Will No	ot
					Recur:	
					Activities Director will monit	tor
					smoking assessments on 5	
					residents weekly x 4 weeks,	
					then every 2 weeks x 2 mont	hs.
					Any negative findings will be	

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						RM APPROVED IB NO. 0938-039
NT OF DEFICIENCIES	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155254	A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/30/2024	
		•	STREET ADDRESS, CITY, STATE, ZIP COD 5430 W US 40 GREENFIELD, IN 46140			
(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		ID PREFIX TAG	corrected immediately and forwarded to the Administrat A report of progress will be forwarded to the QA Committee monthly for a minimum 6 months and/or	or.	(X5) COMPLETION DATE
Based in interview, review, the facility resident with admin generating procedur respiratory care. (R. Findings include: The clinical record on 8/30/24 at 11:05 Alzheimer's disease An Annual Minimu 7/26/24, indicated Fimpaired. Resident all activities of daily A respiratory care president 30 had alto	observation, and record failed to supervise a dependent istration of an aerosol re for 1 of 1 reviewed for resident 30) for Resident 30 was reviewed a.m. The diagnoses included a.m. The diagnoses included resident 30 was cognitively 30 was dependent on staff for a living.	F 06	595	Be Accomplished For Those Residents Found To Have Be Affected By The Deficient Practice: Resident 30 was not affected this alleged deficient practice New tubing was obtained and nurse was present to comple administration of aerosol treatment. How Other Residents Having The Potential To Be Affected By The Same Deficient Practice Will Be Identified An What Corrective Action(s) Will Be Taken: All residents receiving aeroso	een by e. d ete	09/17/2024
	R MEDICARE & MEDIC. NT OF DEFICIENCIES OF CORRECTION PROVIDER OR SUPPLIER N CARE GREENFIE SUMMARY S (EACH DEFICIEN REGULATORY OR REGULATORY OR Based in interview, review, the facility tresident with admin generating procedur respiratory care. (Reference of the clinical record on 8/30/24 at 11:05 Alzheimer's disease An Annual Minimu 7/26/24, indicated Resident S impaired. Resident S all activities of daily A respiratory care p Resident 30 had alte to a diagnosis of ast	PROVIDER OR SUPPLIER N CARE GREENFIELD SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION 483.25(i) Respiratory/Tracheostomy Care and Suctioning Based in interview, observation, and record review, the facility failed to supervise a dependent resident with administration of an aerosol generating procedure for 1 of 1 reviewed for respiratory care. (Resident 30)	R MEDICARE & MEDICAID SERVICES NT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER A. BU 155254 B. WI PROVIDER OR SUPPLIER N CARE GREENFIELD SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION F. O. C.	RMEDICARE & MEDICAID SERVICES NT OF DEFICIENCIES OF CORRECTION IDENTIFICATION NUMBER 155254 PROVIDER OR SUPPLIER N CARE GREENFIELD SUMMARY STATEMENT OF DEFICIENCIE (BACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION Respiratory/Tracheostomy Care and Suctioning Based in interview, observation, and record review, the facility failed to supervise a dependent resident with administration of an aerosol generating procedure for 1 of 1 reviewed for respiratory care. (Resident 30) Findings include: The clinical record for Resident 30 was reviewed on 8/30/24 at 11:05 a.m. The diagnoses included Alzheimer's disease. An Annual Minimum Data Set assessment, dated 7/26/24, indicated Resident 30 was dependent on staff for all activities of daily living. A respiratory care plan, revised 8/19/24, indicated Resident 30 had altered respiratory status related to a diagnosis of asthma with an intervention of	R MEDICARE & MEDICAID SERVICES NT OF DEFICIENCIES NT OF DEFICIENCIES OF CORRECTION IDENTIFICATION NUMBER 155254 STREET ADDRESS, CITY, STATE, ZIP COD 5430 W US 40 GREENFIELD SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION AS ULDING OR GREENFIELD, IN 46140 SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION A SUMMARY STATEMENT OF DEFICIENCY TAG STREET ADDRESS, CITY, STATE, ZIP COD 5430 W US 40 GREENFIELD, IN 46140 PREFIX TAG CORRECTION A report of progress will be forwarded to the Administration of accordingly. F 0695 What Corrective Action(s) W Be Accomplished For Those Residents Jown and administration of accordingly. F 0695 What Corrective Action(s) W Be Taken: How Othe	NYT OF DEFCEINCES NYT OF DEFCEINCES OF CORRECTION 155254 22) MULTIPLE CONSTRUCTION 155254 23) MULTIPLE CONSTRUCTION 155254 24) MULTIPLE CONSTRUCTION 155254 25) MULTIPLE CONSTRUCTION 155254 25) MULTIPLE CONSTRUCTION 155254 26) MULTIPLE CONSTRUCTION 155254 26) MULTIPLE CONSTRUCTION 155254 27) MULTIPLE CONSTRUCTION 155254 28) MULTIPLE CONSTRUCTION 155254 27) MULTIPLE CONSTRUCTION 155254 28) MULTIPLE CONSTRUCTION 155254 28) MULTIPLE CONSTRUCTION 155254 28) MULTIPLE CONSTRUCTION 155254 28) MULTIPLE CONSTRUCTION 155254 29) MULTIPLE CONSTRUCTION 155254 29) MULTIPLE CONSTRUCTION 155254 29) MULTIPLE CONSTRUCTION 155254 20) MULTIPLE CONSTRUCTION 257254 257254 257254 257254 2572554 2572554 2572555

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30 every six hours.

A physician order, dated 6/19/24, indicated to administer an aerosolized medication to Resident

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What Measures Will Be Put

Into Place and What Systemic

practice.

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OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED 155254 B. WING 08/30/2024 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 5430 W US 40 APERION CARE GREENFIELD GREENFIELD, IN 46140 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE Changes Will Be Made To During an observation on 8/27/24 at 1:46 p.m., **Ensure That The Deficient** Resident 30 was sitting in a wheelchair in the **Practice Does Not Recur:** resident's room. A nebulizer was running with the tubing detached from the face mask and the mask Nursing staff were in-serviced was placed under Resident 30's chin. on 9/4/24 over the **Nebulizer-Medication** During an observation and interview on 8/27/24 at administration policy to 1:48 p.m., Licensed Practical Nurse (LPN) 13 was address that a licensed nursing at the nurses' station. LPN 13 entered Resident staff must remain with 30's room to find Resident 30 with the nebulizer residents while administering detached with the face mask pulled under aerosol treatments unless a Resident 30's chin. LPN 13 stated, "[Resident 30] resident has been assessed. pulls [Resident 30's] treatment off all the time." authorized to self administer LPN 13 stated, Resident 30 should "probably" be and Plan of Care updated to supervised during administration of aerosolized reflect this assessment. medication and was not able to self-administer the aerosolized treatment. LPN 13 retrieved new **How The Corrective Action(s)** tubing then completed administration of the Will Be Monitored To Ensure aerosol treatment. The Deficient Practice Will Not Recur: A policy entitled, "Nebulizer- Medication Administration", was provided by the Director of DON/Designee will monitor 5 Nursing on 8/30/24 at 8:40 a.m. The policy residents on aerosol treatments indicated staff will " ... Remain with the resident for weekly times 4 weeks, then the treatment unless the resident has been every 2 weeks x 2 months. Any assessed and authorized to self- administer ..." negative findings will be corrected immediately and 3.1-47(a)(6) forwarded to the Administrator. A report of progress will be forwarded to the QA Committee monthly for a minimum 6 months and/or 100% compliance and plan will be adjusted accordingly.

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483.45(g)(h)(1)(2)

Label/Store Drugs and Biologicals

F 0761

SS=D

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TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG CROSS-REFERENCED TO THE APPROPRIATE DATE Bldg. 00	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155254		(X2) MULTIPLE A. BUILDING B. WING	E CONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 08/30/2024		
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION Bldg. 00 Based on observation, interview, and record review, the facility failed to ensure medication storage rooms did not contain expired supplies for 2 of 2 medication rooms observed. (Facility) Findings include: An observation conducted of Medication Storage Room 2, on 8/28/24 at 9:40 a.m., indicated a urinary catheter with expiration of 2022 and a box of tuberculin syringes with expiration of 2023. An observation conducted of Medication Storage Room 1 with Registered Nurse (RN) 12, on 8/28/24 at 9:45 a.m., indicated a box of tuberculin syringes with expiration after ysyringes expired, on 4/30/23, and six safety syringes with an expiration date of 3/1/24. RN 12 indicated there was a supply room with all needed medical supplies and the medication storage rooms to ensure the supply items were not expired. A policy titled Medication Storage, revised 7/2/19, was provided by the Executive Director on 8/28/24 at 2:10 p.m. The policy indicated, "4 Facility should ensure that medications and biologicals PREFIX TAG What Corrective Action(s) Will Be Accomplished For Those Residents Found To Have Been Affected By The Deficient Practice: No residents were affected by this alleged deficient practice. How Other Residents Having The Potential To Be Affected By The Po				5430 W US 40			
Based on observation, interview, and record review, the facility failed to ensure medication storage rooms did not contain expired supplies for 2 of 2 medication rooms observed. (Facility) Findings include: Findings include: An observation conducted of Medication Storage Room 2, on 8/28/24 at 9:40 a.m., indicated a urinary catheter with expiration of 2022 and a box of tuberculin syringes with expiration of 2023. An observation conducted of Medication Storage Room 1 with Registered Nurse (RN) 12, on 8/28/24 at 9:45 a.m., indicated a box of tuberculin safety syringes expired, on 4/30/23, and six safety syringes with an expiration date of 3/1/24. RN 12 indicated there was a supply room with all needed medical supplies and the medication storage rooms would consist of medical supplies needed for the daily tasks. It was the nurses' responsibility to check the medication storage rooms to ensure the supply items were not expired. A policy titled Medication Storage, revised 7/2/19, was provided by the Executive Director on 8/28/24 at 2:10 p.m. The policy indicated, "4. Facility should ensure that medications and biologicals of the safety systemic What Corrective Action(s) Will Be Put Into Place and What Systemic What Measures Will Be Put Into Place and What Systemic	PREFIX TAG	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP	BE COMPLETION	
stored separate from other medications until destroyed or returned to the supplier" Ensure That The Deficient Practice Does Not Recur: Licensed nursing staff were in-serviced on 9/4/24 over Medication Storage policy and procedure to include medical supplies that have an	Bldg. 00	review, the facility storage rooms did n 2 of 2 medication room. Findings include: An observation con. Room 2, on 8/28/24 catheter with expiratuberculin syringes. An observation con. Room 1 with Regist at 9:45 a.m., indicat syringes expired, or syringes with an expindicated there was medical supplies an rooms would consist for the daily tasks. I responsibility to che rooms to ensure the expired. A policy titled Med was provided by the at 2:10 p.m. The poshould ensure that in that: (1) have an expectation of the destroyed or returned.	failed to ensure medication of contain expired supplies for sooms observed. (Facility) ducted of Medication Storage at 9:40 a.m., indicated a urinary tion of 2022 and a box of with expiration of 2023. ducted of Medication Storage are dered Nurse (RN) 12, on 8/28/24 and a box of tuberculin safety at 4/30/23, and six safety piration date of 3/1/24. RN 12 a supply room with all needed at the medication storage at of medical supplies needed at was the nurses' each the medication storage supply items were not iteation Storage, revised 7/2/19, at Executive Director on 8/28/24 licy indicated, "4. Facility medications and biologicals pired date on the labelare in other medications until	F 0761	Be Accomplished For Those Residents Found To Have Affected By The Deficient Practice: No residents were affected this alleged deficient practice. Medication storage rooms have been audited, expired supplies have been disposed of, and new supplies were obtained. How Other Residents Have The Potential To Be Affect By The Same Deficient Practice Will Be Identified What Corrective Action(s) Be Taken: All residents have the potential to be affected by alleged deficient practice. What Measures Will Be Pullito Place and What Syste Changes Will Be Made To Ensure That The Deficient Practice Does Not Recur: Licensed nursing staff we in-serviced on 9/4/24 over Medication Storage policy procedure to include medication.	se Been I by ge n olies ing ed And Will this	

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155254	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 08/30/2024		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 5430 W US 40 GREENFIELD, IN 46140				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
				How The Corrective Action() Will Be Monitored To Ensure The Deficient Practice Will N Recur: DON/Designee will monitor medication storage rooms for expired medical supplies weekly times 4 weeks, then every 2 weeks for 2 months. Any negative findings will be corrected immediately and forwarded to the Administrat A report of progress will be forwarded to the QA Committee monthly for a minimum 6 months and/or 100% compliance and plan w be adjusted accordingly.	ot ot or ot		
F 0770 SS=D Bldg. 00	failed to ensure Res drawn per physician reviewed for labora Findings include:	and record review, the facility ident 19 had a routine lab a order for 1 of 1 resident tory services.	F 0770	What Corrective Action(s) W Be Accomplished For Those Residents Found To Have Be Affected By The Deficient Practice: Res 5 was not affected by the alleged deficient practice. Re 5 thyroid level will be drawn	een nis		
		for Resident 19 was reviewed o.m. The medical diagnoses idism.		on 9/17/24. How Other Residents Having	g		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155254		(X2) MULTIPLE C A. BUILDING B. WING	CONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 08/30/2024			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 5430 W US 40 GREENFIELD, IN 46140				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	(X5) COMPLETION DATE		
	7/26/24, indicated F impaired. A physician order, or	um Data Set assessment, dated Resident 19 was cognitively dated 5/23/24, indicated ix months to review Resident		The Potential To Be Affected By The Same Deficient Practice Will Be Identified A What Corrective Action(s) N Be Taken: All residents have the potential be affected by this alleger	And Will ntial		
	lab was unable to of tests and "Will try r During an interview Executive Director	note, dated 5/23/24, indicated brain blood for the routine next lab day" 7, on 8/30/24 at 2:15 p.m., the indicated that the facility could abs were obtained for Resident		Into			
	11's thyroid levels i level lab was "miss	n May of 2024. The thyroid ed" in May 2024. The nursing the for obtaining labs per		A lab audit was completed ensure Labs were schedul as ordered.	ed		
	Laboratory/Radiolo provided by the Soc 8/30/24 at 2:10 p.m purpose of the polic	Physician Notification of gy/Diagnostic Results," was sial Services Director on . The policy indicated the cy was to, "assure physician		Nursing staff was in-service on 9-12-24 on the Physician Notification of Laboratory/Radiology/Diag c Results policy.	1		
	ordered diagnostic (3.1-49(a)	ests are performed"		How The Corrective Action Will Be Monitored To Ensur The Deficient Practice Will Recur:	re		
				ADON/designee will audit residents lab results week! scheduled work days x 4 weeks, then every other we x 8 weeks. Any negative findings will be corrected immediately and forwarded the Administrator. A report progress will be forwarded	y on ek to of		

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NAME OF PROVIDER OR SUPPLIER APERION CARE GREENFIELD (X4) ID SUMMARY STATEMENT OF DEFICIENCIE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) (X5) US 40 GREENFIELD, IN 46140 (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG THE QA Committee monthly for a minimum 6 months and/or	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		· /	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
NAME OF PROVIDER OR SUPPLIER APERION CARE GREENFIELD (X4) ID SUMMARY STATEMENT OF DEFICIENCIE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG REGULATORY OR LSC IDENTIFYING INFORMATION STREET ADDRESS, CITY, STATE, ZIP COD 5430 W US 40 GREENFIELD, IN 46140 (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG THE QA Committee monthly for a minimum 6 months and/or	AND PLAN OF	F CORRECTION	IDENTIFICATION NUMBER					
APERION CARE GREENFIELD (X4) ID SUMMARY STATEMENT OF DEFICIENCIE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION (X5) PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFEREDED TO THE APPROPRIATE DEFICIENCY) TAG THE QA Committee monthly for a minimum 6 months and/or			155254	B. WI	B. WING 08/30/2024			
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE The QA Committee monthly for a minimum 6 months and/or					5430 W US 40			
TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG THE QA Committee monthly for a minimum 6 months and/or	(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DROVIDED'S DI AN OF CODDECTION	-	(X5)
TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG THE QA Committee monthly for a minimum 6 months and/or	PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE.	COMPLETION
a minimum 6 months and/or	TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
be adjusted accordingly.						a minimum 6 months and/or 100% compliance and plan v		
F 0791 483.55(b)(1)-(5) SS=D Routine/Emergency Dental Srvcs in NFs Bldg. 00	SS=D		cy Dental Srvcs in NFs					
F 0791 What Corrective Action(s) Will 09/17/2024			F 07	791	What Corrective Action(s) W	ill	09/17/2024	
Based on observation, interview, and record Be Accomplished For Those	I					-		
review, the facility failed to ensure dental services Residents Found To Have Been		•					en	
were provided timely to a resident with no bottom dentures for 1 of 2 residents reviewed for dental Affected By The Deficient Practice:	I	•	•			-		
status and services. (Resident 34) Resident 34 was not affected by							l hv	
this alleged deficient practice.		status and services.	(Resident 5 1)				-	
Findings include: Resident 5 has a scheduled		Findings include:					.	
dental appointment on 9/17/24		Ü					24	
The clinical record for Resident 34 was reviewed		The clinical record	for Resident 34 was reviewed			1		
on 8/28/24 at 1:00 p.m. His diagnoses included, How Other Residents Having		on 8/28/24 at 1:00 p	ρ.m. His diagnoses included,			How Other Residents Having	g	
but were not limited to, hemiplegia and The Potential To Be Affected	I					The Potential To Be Affected		
hemiparesis, major depressive disorder, and By The Same Deficient						I -		
hypertension. He was admitted to the facility on Practice Will Be Identified And			as admitted to the facility on					
1/25/22. What Corrective Action(s) Will		1/25/22.					ill	
The 2/25/22 ancillary services consent form		The 2/25/22 ancilla	iru services consent form			Be Taken:		
indicated Resident 34 consented to receiving			-					
dental services in the facility. All residents have the potential						All residents have the potent	tial	
to be affected by this alleged			,			■		
The 2/9/22 dentures care plan, revised 7/15/24, deficient practice	,	The 2/9/22 dentures	s care plan, revised 7/15/24,					
indicated he wore upper dentures with an What Measures Will Be Put Into		indicated he wore u	ipper dentures with an			What Measures Will Be Put I	nto	
intervention to refer to the dentist routinely and Place and What Systemic		intervention to refer	r to the dentist routinely and			_		
as needed. Changes Will Be Made To		as needed.				1 -		
Ensure That The Deficient		TTI 10/00/20 1						
The 10/30/22 physician's order indicated he may Practice Does Not Recur:			-			Practice Does Not Recur:		
be seen by the dentist, as needed.		be seen by the denti	ist, as needed.			An audit was sampleted to		
The 8/12/24 Ancillary Services Assessment form An audit was completed to ensure timely dental services		The 8/12/24 Apoille	ary Services Assessment form				e	
indicated Resident 34 needed assistance with are provided.			-			<u>-</u>		

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155254		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 08/30/2024	
	PROVIDER OR SUPPLIER N CARE GREENFIELD	5430 W	ADDRESS, CITY, STATE, ZIP COD V US 40 NFIELD, IN 46140		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION dental or dentures.	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
	The 8/13/24 Significant Change MDS (Minimum Data Set) Assessment indicated he was cognitively intact.		SSD was in-serviced on ancillary services on 9-12-24		
	An observation and interview were conducted with Resident 34 in his room on 8/28/24 at 1:09		How The Corrective Action(Will Be Monitored To Ensure The Deficient Practice Will N Recur:	•	
	p.m. He indicated he had top dentures but needed bottom dentures. He hadn't seen the dentist at all since he'd been in the facility. Resident 34 was wearing his top dentures but had no bottom dentures.		SSD/designee will audit 5 residents dental services weekly on scheduled workdays, then every other		
	There were no dental consultations in Resident 34's clinical record. An interview was conducted with the SSD (Social		week x 8 weeks. Any negative findings will be corrected immediately and forwarded to the Administrator. A report of progress will be forwarded to	to of	
	Services Director) on 8/29/24 at 10:33 a.m. The SSD indicated they'd worked at the facility since November 2023. The facility used a specific provider for dental services. The dental provider gathered consent forms and scheduled		the QA Committee monthly f a minimum 6 months and/or 100% compliance and plan v be adjusted accordingly.	or	
	appointments for residents. The dental provider remained in touch with the SSD to let them know when they would be coming to the facility. At each MDS assessment, the SSD would reach out to their dental provider, if the resident needed				
	services. The SSD thought the dental provider was in the facility within the last few months but was not sure of the date. The SSD reviewed Resident 34's clinical record at this time and				
	indicated he did not see that Resident 34 had received dental services in the facility, at least since he'd worked there.				
	The Dental Services and Loss or Damage of Dentures policy was provided by the SSD on 8/29/24 at 12:23 p.m. It read, "The facility will, if necessary or requested by the resident, assist				

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Event ID:

82EG11 Facility ID: 000157

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	a. building <u>00</u>			COMPLETED	
		155254	B. W	B. WING 08/30/2024			/2024	
				STREET	ADDRESS, CITY, STATE, ZIP COD			
NAME OF P	PROVIDER OR SUPPLIER	t			/ US 40			
APFRION	N CARE GREENFIE	ELD			NFIELD, IN 46140			
			-		T		1	
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION	+	TAG	DEFICIENCY)		DATE	
	with scheduling appointments for dental services, arranging for transportation to and from the dental							
		d promptly refer residents						
	with lost or damaged dentures for dental services." The On-Site Health Care Services policy was							
provided by the SSD on 8/29/24 at 12:23 p.m. It read, "It is the policy of the facility to assist residents in arranging health services on site as needed per resident request. Standards: 1)								
	*	appointments for ancillary						
		ed by resident. 2) On-Site						
	services available:	- ·						
	3.1-24(a)(1)							
	3.1-24(a)(3)							
F 0814	483.60(i)(4)							
SS=F	Dispose Garbage	and Refuse Properly						
Bldg. 00								
			F 08	314	What Corrective Action(s) W		09/17/2024	
		on, interview, and record			Be Accomplished For Those			
		failed to ensure trash was			Residents Found To Have Be	en		
		e dumpster and lids were			Affected By The Deficient			
	_	ster for 52 of 52 residents in			Practice:			
	the facility.				No residents were affected b	-		
	Findings include:				this alleged deficient practic	e.		
	i maniga metude.				How Other Residents Having	~		
	A tour of the kitche	n was conducted with the DM			The Potential To Be Affected	_		
		on 8/27/24 at 11:15 a.m.			By The Same Deficient			
	(Practice Will Be Identified Ar	nd		
	During the tour, an	observation was made of the			What Corrective Action(s) W			
	-	rea. There were two dumpsters			Be Taken:			
	-	ocated near the outside dry						
		Each dumpster had two lids.						
	_	eft dumpster, when facing the			All residents have the potent	tial		
					to be affected by this alleged			
	-	dumpsters, was completely opened. There was a clear bag of trash on the ground to the left of the			deficient practice.			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		` ′	ULTIPLE CO	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED			
11112 12111	or conduction	155254	B. W			08/30/2024		
NAME OF PROVIDER OR SUPPLIER APERION CARE GREENFIELD				STREET ADDRESS, CITY, STATE, ZIP COD 5430 W US 40 GREENFIELD, IN 46140				
PREFIX (EACH DEFICIEN		STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		DATE		
	left dumpster. There was a blue glove on the ground to the right of the left dumpster. There were several bags of trash inside of the opened dumpster. An interview was conducted with the DM during observation of the outside dumpster area. She indicated she was unable to reach the dumpster door. On 8/28/24 at 10:04 a.m. and 8/29/24 at 11:28 a.m., the same dumpster lid as reference in the 8/27/24, 11:15 a.m. kitchen tour was observed open again. The Garbage and Rubbish Disposal policy was provided by the MDSC (Minimum Data Set Assessment Coordinator) on 8/30/24 at 10:52 a.m. It read, "Procedure: 4. All containers will be provided with tight-fitting lids or covers, and will be leak proof and waterproof8. Outdoor trash receptacles will be kept covered and the surrounding area kept free of litter."				What Measures Will Be Put In Place and What Systemic Changes Will Be Made To Ensure That The Deficient Practice Does Not Recur: Staff were inserviced on the Garbage and Rubbish Dispospolicy.			
					How The Corrective Action(s Will Be Monitored To Ensure The Deficient Practice Will N Recur:			
					Admin/designee will audit the outside trash receptacles weekly on scheduled workdays, then every other week x 8 weeks. Any negative findings will be corrected immediately. A report of progress will be forwarded to the QA Committee monthly for a minimum 6 months and/or 100% compliance and plan we be adjusted accordingly.	e o or		
F 0880 SS=E Bldg. 00	review, the facility bags when transporensure soiled linent bins located in the h		F 0	880	What Corrective Action(s) W Be Accomplished For Those Residents Found To Have Be Affected By The Deficient Practice: Residents 5,11,29,30,36,45 at 150 were not affected by this	een nd		

STATEMENT OF DEFICIENCIES X1		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	IULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	00	COMPLETED	
		155254	B. WING 08/30/2024				
		<u> </u>		STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER				/ US 40		
APERION	N CARE GREENFIE	ELD			NFIELD, IN 46140		
_			1				
(X4) ID		STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECT		(X5)	
PREFIX	,	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
TAG		after resident care, prior to	-	TAG		DATE	
		r 2 of 2 soiled utility bins			alleged deficient practice. Ho	ow	
	_	1 of 1 random observation of			were they proven not to be		
	-	rtation by staff; and 7 of 7			affected? Psychosocial assessments completed 9-17	7 24	
	_	or resided in rooms with a			showing no psychosocial	7-24	
		e in EBP (enhanced barrier			distress.		
		lents 5, 11, 29, 30, 36, 45, and			MISHESS.		
	150)	5, 11, 27, 50, 50, 75, and			How Other Residents Having	n	
	100)				The Potential To Be Affected	<u> </u>	
	Findings include:				By The Same Deficient	· [
					Practice Will Be Identified A	nd	
	On 8/27/24 at 1:10	p.m., an observation of a soiled			What Corrective Action(s) W		
		way was made. There was			Be Taken:		
		nen hanging out of the bin.					
		ed linen was piled so high			All residents residing in the		
		the lid was unable to be closed			facility have the potential to		
	and was resting on top of the soiled linen.				affected.		
	_						
	On 8/29/24 at 10:16	a.m., an observation of a soiled			What Measures Will Be Put		
	linen bin in the hall	way near the social services			Into Place and What Systemi	ic	
	office was made. Tl	nere was white linen hanging			Changes Will Be Made To		
		ed over the side. The linen		Ensure That The Deficient			
		oin was not contained within			Practice Does Not Recur:		
	the bin or within a b	oag.					
					Staff were in-serviced on		
		onducted with CNA (Certified			9-12-24 on the Linen Handlin	g	
	-	10, who happened to be in the			Principles policy and		
		ferenced soiled linen bin, on			Donning/doffing PPE policy		
		n. She indicated they brought					
		n the residents' rooms and					
		e bins in the hallway, as they					
		n itself into residents' rooms.			How The Corrective Action(
		shift, they brought the soiled			Will Be Monitored To Ensure		
	linen bins into the s	oiled linen room.			The Deficient Practice Will N	ot	
	0.00015				Recur:		
		p.m., an observation of CNA 11					
		ked down the hallway from the			DON/Designee will complete		
		m area towards the dining room			daily IP rounds on scheduled	d	
	_	l a cloth bed pad partially			workdays x 4 weeks, then		
rolled up in her gloved hand. There was a brown				weekly x 8 weeks that includ	e		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		IDENTIFICATION NUMBER	a. building <u>00</u>			COMPLETED	
		155254	B. WING 08/30/2024				2024
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF PROVIDER OR SUPPLIER				5430 W			
ADEDION	N CARE GREENFIE	=I D			IFIELD, IN 46140		
AFERION CARE GREENFIELD				GIVELIV			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	ΓE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE	
		oor in three spots in the area			monitoring of soiled linen,		
		e employee break room and the			ensuring trash bins lids are		
		I 6 was observed to bend over			closed, and proper disposal	of	
	and pick up the bro	wn substances from the floor.			PPE. Any negative findings w	vill	
					be corrected immediately and		
		onducted with LPN 6 on			forwarded to the Administrat	or.	
		. She indicated she didn't know			A report of progress will be		
		stance was and just "picked it			forwarded to the QA		
	up."				Committee monthly for a		
	0.0000				minimum 6 months and/or		
		a.m., an observation of a soiled			100% compliance and plan w	ill	
	linen bin in the hallway near the beauty shop was				be adjusted accordingly.		
	made. There was unbagged, soiled linen hanging						
		unbagged, soiled linen was					
		the bin, that the lid was					
		and was resting on top of the					
	soiled linen.						
	A :	- de-st-de-side CNIA 4					
		onducted with CNA 4 on					
	8/30/24 at 10:19 a.r	icated the soiled linen was					
		bag. They bagged the soiled					
		ts' room, then put it into the					
		he hallway. He stated, "I'm not					
	sure why this isn't is						
	Saic why this isn't i	n u oug.					
	On 8/27/24 at 11·12	2 a.m., an observation of an					
		eptacle in the hallway outside					
		n was made. The receptacle					
		e was trash visible inside of the					
		ras a sign on the doorway					
	_	n was being utilized by a					
		n EBP (enhanced barrier					
		on control intervention					
	designed to reduce						
		organisms that employs					
		glove use during high contact					
	resident care activit						
	On 8/27/24 at 1:05 p.m., an observation of an						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155254		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING 00 COMPLETED B. WING 08/30/2024			PLETED			
NAME OF PROVIDER OR SUPPLIER APERION CARE GREENFIELD			STREET ADDRESS, CITY, STATE, ZIP COD 5430 W US 40 GREENFIELD, IN 46140					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	RRECTION SHOULD BE APPROPRIATE	(X5) COMPLETION DATE		
	of Resident 5's room had no lid and there	eptacle in the hallway outside in was made. The receptacle was used PPE (personal int,) including gowns and e of the receptacle.						
	uncovered trash recof Resident 11's and The receptacle had visible inside of the PPE. There was a signal of the transfer was a signal of transfer was a sin	p.m., an observation of an eptacle in the hallway outside I Resident 30's room was made. no lid and there was trash receptacle, including used ign on the doorway indicating gutilized by a resident who						
	uncovered trash recof Resident 36's and made. The receptactrash visible insideused PPE. There was	p.m., an observation of an eptacle in the hallway outside defended Resident 150's room was leel had no lid and there was of the receptacle, including as a sign on the doorway has being utilized by a EBP.						
	uncovered trash rec of Resident 29's and The receptacle had visible inside of the PPE. There was a si	p.m., an observation of an eptacle in the hallway outside described Resident 45's room was made. In olid and there was trash receptacle, including used agn on the doorway indicating the state of the s						
	(Assistant Director p.m. He indicated s the hallway and thruncovered trash rec where the lids to the	onducted with the ADON of Nursing) on 8/27/24 at 1:07 taff were doffing their PPE in owing it away in the eptacles. He did not know e trash receptacles were, but ald probably be covered.						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155254		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING 00 COMPLETED B. WING 08/30/2024						
NAME OF PROVIDER OR SUPPLIER APERION CARE GREENFIELD			5430 \	STREET ADDRESS, CITY, STATE, ZIP COD 5430 W US 40 GREENFIELD, IN 46140				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE			
F 0881 SS=D Bldg. 00	provided by the Soc 8/30/24 at 2:10 p.m proper handling of spersonal laundry to microorganisms. Ghampers shall be trade Department on a regoverflowing by assilinens shall be carefinward, and placed soiled linen contain not transported open in plastic bag.)" 3.1-18(b)(1)(A) 3.1-18(b)(2) 3.1-18(j) 483.80(a)(3) Antibiotic Steward Based on interview failed to ensure an athe treatment of a unit of 2 residents review (Resident 45) Findings include: The clinical record on 8/30/24 at 11:30 but were not limited disorder, and recurrance of the progress note, daindicated a urine specific property of the progress note, daindicated a urine specific property of the progress note, daindicated a urine specific property of the progress note, daindicated a urine specific property of the progress note, daindicated a urine specific property of the progress note, daindicated a urine specific property of the prop	and record review, the facility intibiotic was appropriate for rinary tract infection (UTI) for ewed for antibiotic therapy. for Resident 45 was reviewed a.m. The diagnoses included, it to, dementia, psychotic	F 0881	What Corrective Action(s) Will Be Accomplished For Those Residents Found To Have Be Affected By The Deficient Practice: Resident 45 was not affected this alleged deficient practice. MD was notified, resident asymptomatic, no new order received. How Other Residents Having The Potential To Be Affected By The Same Deficient Practice Will Be Identified An What Corrective Action(s) Will Be Accomplying the Same Deficient Practice Will Be Identified An What Corrective Action(s) Will Be Identified An What Correc	een by e. s			

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO			(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		a. building <u>00</u>		COMPLETED	
		155254	B. WING 08/30/2024				
NAME OF E	PROVIDER OR SUPPLIER		•	STREET.	ADDRESS, CITY, STATE, ZIP COD		
					V US 40		
APERIO	N CARE GREENFIE	ELD		GREEN	NFIELD, IN 46140		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	TE COMPLETI	ON	
TAG		R LSC IDENTIFYING INFORMATION	-	TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIADED TO THE APPROPRIADED CONTROL OF THE APPROPRIATED CONTROL OF THE APPROPRIATED CONTROL OF THE APPROPRIADED CONTROL OF THE APPROPRIATED CONTROL OF THE APPROPRI	DATE	
		entify and quantify the			Be Taken:		
		esent in a urine sample and					
	determine their sens	sitivity to various antibiotics).			All registents because the material	ial	
	A physician note d	ated 7/10/24, indicated a			All residents have the potent		
		r a UTI. The urine culture was			to be affected by this alleged		
		results were not available (on			deficient practice What Measures Will Be Put I	ato.	
		vas to start Macrobid 100			Place and What Systemic	iio	
	milligrams twice da				Changes Will Be Made To		
	immigrams twice da	my for / days.			Ensure That The Deficient		
	A care nlan initiate	ed 7/11/24, indicated Resident			Practice Does Not Recur:		
	_	nterventions included, but			Tuctice Does Not Necdi.		
		administer antibiotic therapy			MD and NP in-serviced on		
		nonitor laboratory results.			antibiotic stewardship and		
	presented and in	1000101			McGreer criteria on 9-11-24		
	A progress note, da	ted 7/12/24 at 10:31 p.m.,					
		45 was being treated for a UTI			Nursing staff was in-service	d	
		milligrams twice daily until			on the Antibiotic Stewardshi		
		ysis and culture with sensitivity			program on 9-12-24.		
	I	Practitioner was notified and					
	indicated to continu	e Macrobid treatment, as			How The Corrective Action(s)	
	previously ordered,	for a UTI.			Will Be Monitored To Ensure		
					The Deficient Practice Will N	ot	
	_	ed 7/12/24, indicated a			Recur:		
		h culture and sensitivity was					
		ture indicated the organism as			ADON/designee will audit		
		BILIS". The culture and			antibiotic usage daily on		
	•	ave Macrobid as an antibiotic			scheduled workdays x 4 wee	ks,	
	listed to determine i				then weekly x 8 weeks. Any		
	"resistant", or "inter	rmediate".			negative findings will be		
		11 4 312 11 22 2			corrected immediately and		
	_	d by the National Institutes of			forwarded to the Administra	or.	
		nal Library of Medicine, dated			A report of progress will be		
	· ·	was reviewed on 8/30/24 at 3:20			forwarded to the QA		
	1 ~	icated the following,			Committee monthly for a		
		generic drug name and			minimum 6 months and/or		
		odantin both contain the drug			100% compliance and plan v	7111	
		n different forms] is active			be adjusted accordingly.		
		on uropathogens, but most					
Proteus speciesare naturally resistantIf urine		1			1		

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/24/2024 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE A. BUILDING 00 COMPLETED B. WING 08/30/2024			LETED				
NAME OF PROVIDER OR SUPPLIER APERION CARE GREENFIELD				STREET ADDRESS, CITY, STATE, ZIP COD 5430 W US 40 GREENFIELD, IN 46140					
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)		
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION		
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE		
	cultures are positive for Proteus speciesan alternate agent should be selected" A policy titled Antimicrobial Stewardship Program, undated, was provided by the Minimum Data Set (MDS) Nurse on 8/30/24 at 12:00 p.m. The policy indicated the following, "Antibiotic Stewardship Program (ASP). This program will promote appropriate use of antibiotics in our facilityThis multidisciplinary team will regularly review appropriateness of antibiotic courses and make recommendations for adjustment in practice where necessarymonitor and report patterns of antibiotic use and resistance"								

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