CENTERS FOR	R MEDICARE & MEDIC	AID SERVICES			OMB NO. 0938-039	
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE (CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		COMPLETED	
		155820	B. WING		04/09/2025	
		1000_0			0 1/00/2020	
NAME OF F	PROVIDER OR SUPPLIER	3		Γ ADDRESS, CITY, STATE, ZIP COD		
01 1	No vident on sorreit.		1236	LINCOLN AVE		
APERIO	N CARE LINCOLN		EVAN	SVILLE, IN 47714		
(X4) ID	SIIMMARV	STATEMENT OF DEFICIENCIE	ID		(X5)	
PREFIX			PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION	
	·	ICY MUST BE PRECEDED BY FULL		CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	AIE	
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION	TAG	DELICE:NO.	DATE	
F 0000						
DI 1 00						
Bldg. 00		D 10 1 10 10		1		
		Recertification and State	F 0000	This Plan of Correction is the		
	1	This visit included the		center's credible allegation of		
	Investigation of Co	mplaints IN00456840,		compliance.		
	IN00450874, and II	N00449780.				
				Preparation and/or execution	of	
	Complaint IN00456	5840 - Federal/State deficiencies		this plan of correction does no	ot	
	related to the allega	tions are cited at F584, F677,		constitute admission or agree	ment	
	and F686			by the provider of the truth of	the	
				facts alleged or conclusions s	et	
	Complaint IN00450	0874 - Federal/State deficiencies		forth in the statement of		
	related to the allega	tions are cited at F689.		deficiencies. The plan of		
				correction is prepared and/or		
	Complaint IN00449	9780 - Federal/State deficiencies		executed solely because it is		
		tions are cited at F677, F689,		required by the provisions of		
	F692, and F804			federal and state law		
	10,2, 4114 100 .			Todorar arra stato raw		
	Survey dates: April	3, 4, 7, 8, and 9, 2025				
	Facility number: 00					
	Provider number: 1	55820				
	AIM number: 1002	89580				
	Canaua Dad Tyma					
	Census Bed Type:					
	SNF/NF: 44 Total: 44					
	10tai. 44					
	Census Payor Type	•				
	Medicare: 4	-				
	Medicaid: 24					
	Other: 16					
	Total: 44					
	10:41. 77					
	These deficiencies	reflect State Findings cited in				
	accordance with 41					
	Quality review com	ppleted April 17, 2025.				

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

Dena kerschenr RVPO 05/05/2025

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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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155820		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 04/09/2025
	PROVIDER OR SUPPLIER	1236 LI	ADDRESS, CITY, STATE, ZIP COD NCOLN AVE VILLE, IN 47714	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
F 0553 SS=E Bldg. 00	483.10(c)(2)(3) Right to Participate in Planning Care			
	Based on interview and record review, the facility failed to ensure care plan conferences were completed quarterly for 6 of 7 residents reviewed	F 0553	Immediate actions taken for those residents identified:	05/06/2025
	for care plan conferences. (Resident P, Resident S, Resident D, Resident N, Resident B, and Resident F)		Resident P has had their indiv Care Conference scheduled	
	Findings include:		Resident S has had their indiv Care Conference scheduled	idual
	1. On 4/7/25 at 12:35 P.M., Resident P's clinical record was reviewed. Diagnoses included, but were not limited to, cerebral palsy, diabetes		Resident D has had their indiv Care Conference scheduled.	idual
	mellitus, and major depressive disorder. The most current Quarterly Minimum Data Set		Resident N has had their indiv Care Conference scheduled	idual
	(MDS) Assessment, dated 1/25/25, indicated Resident P was cognitively intact.		Resident B has had their indiv Care Conference scheduled	idual
	The most current care plan conference was completed on 10/31/24.		Resident F has had their indiv Care Conference scheduled	idual
	2. On 4/4/25 at 12:40 P.M., Resident S's clinical record was reviewed. Diagnoses included, but were not limited, to dementia, repeated falls, and		2) How the facility identified other residents:	
	major depressive disorder. The most current Quarterly Minimum Data Set		All residents have the potential be affected by the alleged defined practice.	
	(MDS) Assessment, dated 2/20/25, indicated that Resident S had severe cognitive impairment.		Residents reviewed for missed New quarterly care conference Residents and/or representati	es.
	The most current care plan conference was completed on 11/14/24.		invited to scheduled care conferences. SSD has been educated on	
	3. On 4/7/25 at 2:40 P.M., Resident D's clinical record was reviewed. Diagnoses included, but were not limited to, wedge compression fracture of unspecified lumbar vertebra and unsteadiness on		ensuring residents have quarted care conferences scheduled a minimum and documentation care conference attendance.	ta

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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. BU	JILDING	00	COMPLETED	
		155820	B. W	ING		04/09/2025	
				STREET	ADDRESS, CITY, STATE, ZIP COD	<u>. </u>	
NAME OF I	PROVIDER OR SUPPLIEI	₹			INCOLN AVE		
APERIO	N CARE LINCOLN			EVANSVILLE, IN 47714			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE	
	feet.						
	 				3) Measures put into place/		
		uarterly Minimum Data Set			System changes:		
		t, dated 2/18/25, indicated					
	Resident D had sev	ere cognitive impairment.			Residents reviewed for misse		
	TEI .	1 6			New quarterly care conference	es.	
		are plan conference was					
	*	24.4. On 4/4/25 at 12:48 P.M., al record was reviewed.			Residents and/or representati	ves	
					invited to scheduled care		
	_	, but was not limited to, ith diabetic polyneuropathy.			conferences.		
	diabetes illellitus w	in diabetic polyneuropatily.			SSD has been educated on		
	The most recent O	parterly MDS accessment			ensuring residents have quart	torly	
	The most recent Quarterly MDS assessment, dated 3/20/25, indicated Resident N was				care conferences scheduled a	-	
	cognitively intact.	cated Resident IV was			minimum and documentation		
	cognitively intact.				care conference attendance.		
	The clinical record	lacked a care plan conference			care conference attendance.		
	since admission.	nached a care plan comercine			4) How the corrective action		
					will be monitored:	"	
	5. On 4/7/25 at 9:24	4 A.M., Resident B's clinical			wiii zo incintoroa.		
		ed. Diagnosis included, but was			The SSD/Designee will audit	5	
		ertensive encephalopathy.			resident care plans weekly tin		
					four weeks, then monthly for 3		
	The most recent Ar	nnual Minimum Data Set			months to ensure resident and		
	assessment, dated 1	/3/25, indicated Resident B			representative invitations have	e	
	was moderately co	gnitively intact.			been completed with		
					documentation.		
	The clinical record	lacked a care plan conference					
	since 10/10/24.				The SSD/Designee will audit	5	
					resident care plans weekly tim	nes	
		57 A.M., Resident F's clinical			4 weeks, then monthly for 3		
	record was reviewe	d. Diagnosis included, but was			months to ensure the Care Pl	an	
	not limited to, hype	ertension.			Conferences are being held.		
	The most recent Qu	narterly MDS assessment,			The results of these audits v	vill	
	dated 2/17/25, indi-	cated Resident F was			be reviewed in Quality		
	cognitively intact.				Assurance Meeting monthly	x6	
					months or until an average of	of	
	The clinical record	lacked a care plan conference			100 % compliance or greate		
	since admission.				is achieved x3 consecutive	1	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY						
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>00</u> COM		COMPL	ETED	
		155820	B. WI	NG		04/09/	2025	
	ROVIDER OR SUPPLIER		•	1236 LI	REET ADDRESS, CITY, STATE, ZIP COD 236 LINCOLN AVE /ANSVILLE, IN 47714			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		ΓE	COMPLETION		
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
F 0561 SS=D	On 4/9/25 at 9:19 A for Resident N, Res requested and not properties of the policy titled Compressional Be invited to reinterdisciplinary tea	.M., care plan conferences held ident B, and Resident F were rovided. P.M., the DON provided a ehensive Care Plans that lent and/or representative eview the plan of care with the m either in person, via conference (if available) at			months. The QA Committee will identify any trends or patterns and make recommendations to revise tiplan of correction as indicated			
Bldg. 00	review, the facility resident's choice of reviewed for choice was not completed attend mass. (Reside Finding includes: On 4/4/25 at 9:05 A wanted to go to masher up in time to go the facility at 11:00 On 4/7/25 at 12:35 b record was reviewed.	M., Resident P indicated she is, but staff didn't always get Mass was scheduled daily in A.M. P.M., Resident P's clinical d. Diagnoses included, but cerebral palsy and major	F 05	561	1) Immediate actions taken for those residents identified: Resident P has been provided care and gotten up and attended Mass. Resident P has no signs and/o symptoms of negative outcome. 2) How the facility identified other residents: All residents have the potential be affected by the alleged defining practice. Nursing staff have been education Resident Rights and Choice	am ed or e. I to cient	05/06/2025	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				EY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLETED	
		155820	B. W	ING		04/09/2025	;
				CTREET	ADDRESS SITE STATE SID COD		
NAME OF I	PROVIDER OR SUPPLIER	t			ADDRESS, CITY, STATE, ZIP COD		
4555101					NCOLN AVE		
APERIO	N CARE LINCOLN			EVANS	VILLE, IN 47714		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DDOVIDED'S DI AN OF CODDECTION		(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	COM	MPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	I	DATE
					Non nursing staff have been		
	The most current Q	uarterly Minimum Data Set			educated on Resident Rights	and	
		, dated 1/24/25, indicated that			Choices.		
		nitively intact and was					
	_	(staff does all of the effort) for			3) Measures put into place/		
	toileting and bathin				System changes:		
		D'			gyetem enangee.		
	The most current ca	re plan conference was			Nursing staff have been educa	nted	
		/24. Care plans were reviewed			on Resident Rights and Choic		
	and updated.	, 2 ii culo piuno ii cito i cito i cito			on resident ragnite and onese		
	una apaatea.				Non nursing staff have been		
	Δ current preference	es care plan, initiated 2/12/21,			educated on Resident Rights	and	
	_	esident preferred to get up for			Choices.	arid	
	the day at 10:00 A.M. or as desired.				Choices.		
	the day at 10.00 A.I	vi. of as desired.			4) How the corrective actions		
	Δ current self care (deficit care plan, initiated			will be monitored:	'	
		hat the resident required a			wiii be illoilitorea.		
		the assistance of two staff			The Interdisciplinary Team wil		
	members for safe tr				complete 5 resident interviews		
	memoers for safe tr	ansiers.			week care times four weeks,		
	A current activities	care plan, initiated 4/15/21,			3 times a week for 3 months to		
	indicated the reside	-					
	illulcated the reside.	iit was catholic.			ensure resident preferences a	ria/or	
	Om 4/9/25 at 10.14	A.M. CNA 22 indicated that			choices are being followed.		
		A.M., CNA 23 indicated that			The meeting of the control of the co		
		ough staff to get everything			The results of these audits w	""	
	done.				be reviewed in Quality		
	0 4/0/25 4 11 05	AM D '1 (D 1 1			Assurance Meeting monthly		
		A.M., Resident P was observed			months or until an average o		
		The resident indicated that			100 % compliance or greate	r	
	-	eted her shower and she was			is achieved x3 consecutive		
		get her out of bed with the			months. The QA Committee		
	mechanical lift.				will identify any trends or		
					patterns and make	_	
		A.M., the Administrator			recommendations to revise t	-	
		the Resident Rights, revised			plan of correction as indicate	ed.	
	· ·	ted "You have the right to and					
	the facility must pro						
		hrough support of resident					
	_	he right to choose activities,					
	schedulesconsiste	nt with your interests You					

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X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155820	(X2) MULTIPLE C A. BUILDING B. WING	onstruction (X3) DATE SURVEY COMPLETED 04/09/2025
	1236 L	INCOLN AVE	
NCY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
eligious, and community of interfere with the rights of			
and Rules			
esident signed admission ident rights and was provided a idents reviewed for new lent L) w on 4/4/25 at 8:36 A.M., ed she was unaware of her in the facility, and had not an admission packet. A.M., Resident L's clinical record ident L was admitted on included, but was not limited lasm. dmission Minimum Data Set indicated gnitively intact. set was signed 3/21/25 by the rector (SSD) and Resident L. w on 4/8/25 at 1:53 P.M., he signature on the admission	F 0572	1) Immediate actions taken for those residents identified: Resident L has been provided a signed copy of his/her individual resident rights and individual admission paperwork. 2) How the facility identified other residents: All residents have the potential be affected by the alleged deficipractice. The Social Service Director has been educated on providing ea Admission paperwork if requesiby resident and a copy of the Resident Rights 3) Measures put into place/System changes: The Social Service Director has been educated on providing ea Admission paperwork if requesiby resident and a copy of the Resident Rights.	to sient s ch ted
	IDENTIFICATION NUMBER 155820	IDENTIFICATION NUMBER 155820 R STREET 1236 L EVANS STATEMENT OF DEFICIENCIE INCY MUST BE PRECEDED BY FULL RE LSC IDENTIFYING INFORMATION ticipate in other activities, eligious, and community of interfere with the rights of the facility". TAG TAG TOST2 F 0572 F	TAGENTIFICATION NUMBER 155820 R STREET ADDRESS, CITY, STATE, ZIP COD 1236 LINCOLN AVE EVANSVILLE, IN 47714 DEPOTENT PROPERTION (RLSC IDENTIFYING INFORMATION incipate in other activities, sligious, and community of interfere with the rights of he facility". and Rules F 0572 1) Immediate actions taken fo those residents identified: Resident L has been provided a signed copy of his/her individual admission paperwork. The signed to the admission of the facility, and had not an admission packet. A.M., Resident L's clinical record ident L was admitted on included, but was not limited dasm. dmission Minimum Data Set and the state of the resident Rights The Social Service Director has been educated on providing each admission paperwork if reques by resident and a copy of the Resident Rights. The Social Service Director has been educated on providing each admission paperwork if reques by resident and a copy of the Resident Rights. The Social Service Director has been educated on providing each admission paperwork if reques by resident and a copy of the Resident Rights.

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155820	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 04/09/2025
	ROVIDER OR SUPPLIER		1236 L	ADDRESS, CITY, STATE, ZIP COD INCOLN AVE SVILLE, IN 47714	
(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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	SSD indicated resid packets electronical a copy unless they r On 4/9/25 at 12:14 provided an undated Procedures and Gui healthcare profession making their own procedures and procedures and gui healthcare profession making their own procedures and gui healthcare profession making their own procedures are guidely as a contract of the procedure o	ents sign the admission ly and were not provided with equest it. P.M., the Director of Nursing I policy titled Documentation delines that indicated "Each nal shall be responsible for rompt, factual, concise, entries ppropriate, and readable."		will be monitored: ADM/Designee will complete audits 3 times a week for 4 weeks, then weekly times 8 weeks. The results of these audits vibe reviewed in Quality Assurance Meeting monthly months or until an average of 100 % compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise plan of correction as indicated.	x6 of er the
F 0584 SS=E Bldg. 00	interview, the facility sanitary environment public for 11 randor Offensive odors we alcoves and stairwe hallways, in front or outside of rooms 10 Station), dirty show were observed. (Rest Findings include: 1. On 4/3/25 at 9:30 observation, the smether first floor outside	on, record review, and try failed to provide a safe and at for residents, staff, and the m observations on 5 of 5 days. The detected in public hallways, alls (throughout 100-unit of chapel, alcoves on 200 unit, of and 113, Holy Family Nurses and resident room floors and P and Resident D) A.M., during a random all of urine was observed on	F 0584	What corrective actions have been accomplished for those residents found to have been affected by the deficient practice. The urine odor outside the Chhase been removed. The urine odor outside of room and 113 has been removed. The urine odor throughout the unit. The urine odor was removed first floor stairwell.	e nn napel nn 109

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155820	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 04/09/2025
	PROVIDER OR SUPPLIER		1236 L	ADDRESS, CITY, STATE, ZIP COD INCOLN AVE SVILLE, IN 47714	
(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
	observed outside of			The urine odor was removed the hallway near Holy Family Nurses Station.	from
	observation, the stro	Of A.M., during a random ong smell of urine was way outside of the chapel.		The feces odor was removed the alcoves on the second flo	
	observation, the stro observed in the hall	OA.M., during a random ong smell of urine was way in front of the chapel and		Resident P's floor in the room shower room.	n and
		ughout the 100 unit. O A.M., during a random		Resident D's floor in the room shower room.	n and
		ng smell of urine was s throughout the 100 unit.		How the facility will identi other residents having the potential to be affected by the	
	observation, the stro	A.M., during a random ong smell of urine was a-floor stairwell and coming		same deficient practice: All residents have been	
	onto the hallway in			potential to be affected by this alleged deficient practice.	
	observation, the stro	ong smell of urine was way near Holy Family Nurses		Housekeeping Supervisor has been educated on the Facility Housekeeping Policy includin cleaning floor in the rooms an	r's g
		6 A.M., during a random ell of feces was observed in		shower floors. Housekeeping Staff have bee	
	alcoves throughout interview on 4/4/25 indicated that staff of	the second floor.9. In an at 9:13 A.M., Resident P did not clean her room daily.		educated on the Facility's Housekeeping Policy includin cleaning floor in the rooms an	g
	the floor by the bath			shower floors. A Facility wide audit of odors been completed to determine	
	observed to have br	A.M., Resident P's room was own mud stains on the floor or and the shower floor was		cause Measures the facility will tak to ensure that the problem v be corrected and will not red	vill
	10. In an interview	with a family member on 4/3/25		Housekeeping Supervisor habeen educated on the Facility	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLI	ETED
		155820	B. W	ING		04/09/2	2025
				CTREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER	1					
ADEDION	LOADELINGOLN				NCOLN AVE		
APERIO	N CARE LINCOLN			EVANS	VILLE, IN 47714		
(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 OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	at 2:30 P.M., it was	indicated that Resident D's			Housekeeping Policy including	a [
	room was not clean	ed enough and they would			cleaning floor in the rooms and	d	
	find food crumbs be	ehind the drawers when			shower floors.		
	visiting.				Housekeeping Staff have bee	n	
					educated on the Facility's		
	On 4/8/24 at 2:40 P	.M., Resident D's room was			Housekeeping Policy including	g	
	observed to have fo	od crumbs along the wall. The			cleaning floor in the rooms and	-	
	bathroom floor was	sticky by the shower and the			shower floors.		
	shower floor was di	rty.			A Facility wide audit of odors	has	
					been completed to determine		
	On 4/8/25 at 2:45 P	.M., Housekeeper 11 indicated			cause.		
	that there was not a	daily cleaning list. She					
	indicated she was to	old to clean the resident's sink			Quality assurance plans to		
	and toilet, mop the	floors if they were dirty, and			monitor facility performance	to	
	take the trash out da	aily.			make sure that corrections a		
					achieved and are permanent	:	
	During an interview	on 4/9/25 at 3:03 P.M., the			-		
	Director of Nursing	(DON) indicated there should			Housekeeping Supervisor	r and	
	be no offensive sme	ells in the building.			or designee will perform 5		
					observations a week for 12 we	eeks	
	On 4/9/25 at 12:14	P.M., the DON provided a			of resident's rooms, shower flo	oor	
	current, non-dated p	oolicy "Housekeeping			to assure cleanliness.		
	Services Policy." Tl	he policy indicated " it was					
	the policy of the fac	cility to maintain a clean, odor			Housekeeping		
	free, environment in	n all health care and public			Supervisor/Designee will perfo	orm 5	
	areas, which meet the	he sanitation needs of the			observations a week for 12 we	eeks	
	facility for aclear	comfortable environment"			of resident's rooms to ensure		
					floors are clean and shower ro	oom	
	On 4/9/24 at 12:14	P.M., the Director of Nursing			floors are clean.		
		current undated Housekeeping					
	Services Policy that	indicated "The department			Housekeeping		
	shall routinely clear	n the environment of care,			Supervisor/Designee will perfo	orm 5	
	using accepted prac	tices, to keep the facility free			observations a week for 12 we	eeks	
		rs, the accumulation of dust,			of showers rooms to ensure		
	rubbish, dirt and ha	zards".			cleanliness.		
	This citation related	l to Complaint IN00456840.			IDT will complete 5 interviews	a	
					week to ensure resident room		
	3.1-19(f)				floors, shower room floors wer	re	
					maintained in a safe, clean an	d	

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155820	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 04/09/2025
	PROVIDER OR SUPPLIER		1236 L	ADDRESS, CITY, STATE, ZIP COD INCOLN AVE SVILLE, IN 47714	
(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 0622 SS=D Bldg. 00	483.15(c)(1)(i)(ii)(i Transfer and Disc	2)(i)-(iii) harge Requirements		sanitary manner. The results of the above observations, interviews will be reviewed in the Quality Assura Meeting monthly until 100% compliance is achieved for 3 consecutive months. The QAA Committee will identify any tree or patterns and make recommendations to revise the plan of correction as indicated	ance A ends e
	failed to ensure clin with a resident during residents reviewed and Resident D) Findings include: On 4/7/25 at 9:24 A was reviewed. Diagolimited to, hypertenthe The most recent An assessment, dated 1 was moderately cognosistance from staff toileting and transferassistance for bathing the work).	and record review, the facility ical documentation was sent ing a transfer for 2 of 2. For hospitalizations. (Resident in the second in the se	F 0622	How corrective action will be taken for those affected by the alleged deficient practice: Residents have been interview with no negative outcomes not How will the facility identify other residents having the potential to be affected by the same deficient practice? How the facility identified other residents: All residents who have be transferred or discharged have potential to be affected by the same alleged deficient practice. Social Service Director ar Director of Nursing were in-serviced on requirements on notifying the resident and the resident's representative of the transfer or discharge and the reason for the move in writing ensure clinical documentation.	wed ted. ie er een e the e. nd f ee

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>00</u> COMPLETE			ETED
		155820	B. W	ING		04/09/	2025
				CTREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIER	2			INCOLN AVE		
ADEDIO	N CARE LINCOLN						
APERIO	N CARE LINCOLN			EVANS	SVILLE, IN 47714		
(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 DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	tablet by mouth two	times a day for hypertension;			sent with the resident and in a		
	Start date 2/9/24				language and manner they		
					understand. And that the facili	ty	
	Isosorbide Mononit	rate ER (extended release) oral			must send a copy of the notice	e to	
	tablet 60 mg give or	ne tablet by mouth two times a			a representative of the Office	of the	
	day for paroxysmal	atrial fibrillation; Start date			State Long-Term Care		
	2/9/24				Ombudsman.		
	Lisinopril oral table	et 10 mg give one tablet by			The measures the facility wil	I	
	mouth two times a	day for hypertension; Start			take or systems the facility w	vill	
	date 2/9/24				alter to ensure that the		
					problem will be corrected an	d	
	Resident B was tran	nsferred to the hospital on			will not occur:		
	6/25/24 and 12/8/24	1.			Measures put into place/syste	m	
					changes:		
	The clinical record	lacked documentation of			Social Service Director ar	nd	
	advanced directive	information, diagnoses, plan			Director of Nursing were		
	of care, or current n	nedications for the transfer to			in-serviced on requirements of	f	
	the hospital on 6/25	5/24.			notifying the resident and the		
					resident's representative of the	е	
	The clinical record	lacked documentation of			transfer or discharge and the		
	advanced directive	information, diagnoses, plan			reason for the move in writing.	,	
		nedications for the transfer to			ensure clinical documentation	is	
	the hospital on 12/8	3/24.			sent with the resident and in a	l	
					language and manner they		
		note, dated 12/8/24 at 10:04			understand. And that the facili	-	
		hospital called the facility and			must send a copy of the notice		
	requested medication	on record and advanced			a representative of the Office	of the	
	directives that were	not sent with transfer.			State Long-Term Care		
					Ombudsman.		
	_	on 4/9/25 at 12:49 P.M. the			Quality Assurance plans to		
	_	(DON) indicated there was no			monitor facility performance		
		ecords sent with the resident			make sure that corrections a	_	
	I -	6/25/24 or 12/8/24. 2. On 4/7/25			achieved and are permanent		
		ent D's clinical record was			How the corrective action will	be	
	1	es included, but were not			monitored:		
		a, epileptic seizures, wedge			DON/Designee will perform 5		
	_	re of unspecified lumbar			random Medical Record review		
	_	alls, unsteadiness on feet, and			week to ensure the resident a		
	weakness. Resident	D was discharged to the			resident representative have b	een	

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 04/09/2025 155820 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1236 LINCOLN AVE APERION CARE LINCOLN **EVANSVILLE, IN 47714** (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 hospital on 4/4/25 and was anticipated to return. provided written notice of transfer. The most recent Quarterly MDS Assessment, ADM/Designee will perform 5 dated 2/18/25, indicated Resident D had severe random audits to ensure the cognitive impairment, required substantial to Ombudsman have been notified maximal assistance of staff (staff does more than monthly of resident transfer. half of the effort) for toileting, bathing, and The results of these interviews transferring, and had 2 or more falls without injury will be reviewed in Quality since the prior assessment on 1/6/25. Assurance Meeting monthly x6 months or until an average of A nursing progress note, dated 4/4/25 at 3:10 100% compliance or greater is P.M., indicated a new order was received to send achieved x3 consecutive the resident to the hospital for treatment and months. The QA Committee evaluation. will identify any trends or patterns and make A nursing progress note, dated 4/4/25 at 3:41 recommendations to revise the P.M., indicated ambulance staff picked up the plan of correction as indicated. resident from the facility and transported him to the hospital for the possibility of "trauma from a fall". A nursing progress note, dated 4/5/25 at 12:52 P.M., indicated that the hospital called the facility to request Resident D's Medication Administration Record (MAR). It was faxed to the hospital at that time. On 4/9/25 at 12:14 P.M., the Director of Nursing (DON) indicated she was unable to find the transfer documents for Resident D's transfer to acute care on 4/4/25. On 4/9/25 at 12:14 P.M., the DON provided a current undated Discharge/Transfer or Resident policy that indicated "Complete Transfer Form accurately and completely including vital signs ... Ensure that resident's current physical and psycho/social assessment, medications and current treatment is completely described and

available to the receiving facility upon transfer.

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING 00 COMPLETED					
THIS I DININ	o. conduction	155820				04/09/	
	ROVIDER OR SUPPLIER		•	1236 LI	ADDRESS, CITY, STATE, ZIP COD INCOLN AVE SVILLE, IN 47714	•	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	BROWDERIC DI ANI 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)		DEFICIENCY)		DATE
	Assure required "no sent with the residen	otices" (DNR, Will, POA) are nt".					
	3.1-12(a)(3) 3.1-12(a)(5)(A) 3.1-12(a)(6)(B)						
F 0623 SS=D Bldg. 00	483.15(c)(3)-(6)(8 Notice Requireme Transfer/Discharg	nts Before					
J		and record review, the facility	F 06	523	How corrective action will be)	05/06/2025
	failed to ensure a no	otice of transfer was provided			taken for those affected by the	he	
		for 1 of 2 residents reviewed			alleged deficient practice:		
	for hospital transfer	rs. (Resident B)			Residents have been interview		
	E' 1' ' 1 1				with no negative outcomes no	ted.	
	Finding includes:				How will the facility identify		
	On 4/7/25 at 9·24 A	.M., Resident B's clinical record			other residents having the potential to be affected by th	•	
		nosis included, but was not			same deficient practice?	ı c	
	_	sive encephalopathy.			How the facility identified othe	r	
	, 51	1 1 3			residents:		
	The most recent An	nual Minimum Data Set			All residents who have be	en	
	assessment, dated 1	/3/25, indicated Resident B			transferred or discharged have	e the	
		gnitively intact, required partial			potential to be affected by the		
		f (staff do half of the work) for			same alleged deficient practice		
	•	ers, and required substantial			Social Service Director an	nd	
		ng (staff do more than half of			Director of Nursing were	e.	
	the work).				in-serviced on requirements of	T	
	Resident B was tran	asferred to the hospital on			notifying the resident and the resident's representative of the	0	
	6/25/24, 9/8/24, and	_			transfer or discharge and the	G	
		÷			reason for the move in writing	and	
	A list of transfers ar	nd discharges for June,			in a language and manner the		
		cember 2024 sent to the			understand. And that the facili	-	
	ombudsman was red	quested, but failed to be			must send a copy of the notice	-	
	provided.				a representative of the Office	of the	
					State Long-Term Care		
	-	on 4/9/25 at 12:49 P.M., the			Ombudsman.		
		(DON) indicated there was no			T		
	notification to ombi	udsman for June, September, or			The measures the facility wil	I	

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

PRINTED: 05/06/2025 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155820		(X2) MULTIPLE C A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 04/09/2025	
	PROVIDER OR SUPPLIER		1236 L	ADDRESS, CITY, STATE, ZIP COD INCOLN AVE SVILLE, IN 47714	
APERIOI (X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY) take or systems the facility alter to ensure that the problem will be corrected a will not occur: Measures put into place/syst changes: Social Service Director a Director of Nursing were in-serviced on requirements notifying the resident and the resident's representative of the transfer or discharge and the reason for the move in writing in a language and manner th understand. And that the faci must send a copy of the notic a representative of the Office State Long-Term Care	mill md em and of ene g and ey lity be to
				Ombudsman. Quality Assurance plans to monitor facility performance make sure that corrections achieved and are permaner. How the corrective action will monitored: DON/Designee will perform of the random Medical Record revieweek to ensure the resident resident representative have provided written notice of train ADM/Designee will perform of the random audits to ensure the Ombudsman have been notificated in the results of these interviewell be reviewed in Quality Assurance Meeting monthly months or until an average 100% compliance or greate	are it: I be sews a and been nsfer. fied ews y x6 of

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155820		(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 04/09/2025	
APERION	ROVIDER OR SUPPLIER		1236 L EVANS	ADDRESS, CITY, STATE, ZIP COD INCOLN AVE SVILLE, IN 47714	
(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
E 0625	492 45(4)(4)(2)			achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise plan of correction as indicate	the
F 0625 SS=D Bldg. 00	483.15(d)(1)(2) Notice of Bed Hold	d Policy Before/Upon Trnsfr			
	failed to ensure a be transfer for 2 of 2 re hospitalizations. (Re Finding includes: 1. On 4/7/25 at 9:24 record was reviewed not limited to, hyper The most recent An assessment, dated 1 was moderately cognosistance from staff toileting and transfer assistance for bathin the work). Resident B was transfered to be a substance for bathing the work of the clinical record hold provided for the 6/25/24. The clinical record in the clin	and record review, the facility od hold was provided upon esidents reviewed for esident B and Resident D) A.M., Resident B's clinical d. Diagnosis included, but was reensive encephalopathy. Inual Minimum Data Set //3/25, indicated Resident B entitively intact, required partial of (staff do half of the work) for ers, and required substantial eng (staff do more than half of the ers and required substantial eng (staff do more than half of the ers and required substantial eng (staff do more than half of the error to the hospital on the error to th	F 0625	How corrective action will be taken for those affected by the alleged deficient practice: Residents have been interview with no negative outcomes not how will the facility identify other residents having the potential to be affected by the same deficient practice? How the facility identified other residents: All residents who have be transferred or discharged have potential to be affected by the same alleged deficient practice. Social Service Director and Director of Nursing, Nursing Swere in-serviced on requirement of notifying the resident and the reason for the move in writing ensure clinical documentation including Bed Hold Policy is swith the resident upon transfer/discharge. The measures the facility will take or systems the facility will alter to ensure that the	wed ted. ie r een e the e. and otaff ents ne e

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	IULTIPLE CO	ONSTRUCTION	(X3) DATE S	URVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	00	COMPLE	TED
		155820	B. W	ING		04/09/2	2025
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	L.			NCOLN AVE		
APERION	N CARE LINCOLN			EVANSVILLE, IN 47714			
(VA) ID	CIDBARN	CTATEMENT OF DEFICIENCIE	1		<u> </u>	Г	(VE)
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (FACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LISC IDENTIFYING INFORMATION		TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
TAG		on 4/9/25 at 12:49 P.M. the		IAU	problem will be corrected an		DATE
		(DON) indicated there was no			will not occur:	u	
		ecords sent with the resident			Measures put into place/syste	_	
		6/25/24 or 12/8/24. 2. On 4/7/25			changes:	""	
	_	ent D's clinical record was			Social Service Director ar	, d	
		es included, but were not			Director of Nursing, Nursing S		
	_				were in-serviced on requirement	I .	
	limited to, dementia, epileptic seizures, wedge compression fracture of unspecified lumbar				of notifying the resident and the		
	1 -	alls, unsteadiness on feet, and			resident's representative of the		
	_	D was discharged to the			transfer or discharge and the	~	
		nd was anticipated to return.			reason for the move in writing		
		was univerpassed to recorn			ensure clinical documentation		
	The most recent Quarterly Minimum Data Set				including Bed Hold Policy is se	I .	
	(MDS) Assessment, dated 2/18/25, indicated				with the resident upon		
		ere cognitive impairment,			transfer/discharge.		
		to maximal assistance of staff			go.		
	_	in half of the effort) for			Quality Assurance plans to		
	1	nd transferring, and had 2 or			monitor facility performance	to	
		njury since the prior			make sure that corrections a		
	assessment on 1/6/2				achieved and are permanent		
					How the corrective action will		
	A nursing progress	note, dated 4/4/25 at 3:10			monitored:		
	P.M., indicated a ne	ew order was received to send			DON/Designee will perform 5		
	the resident to the h	ospital for treatment and			random Medical Record review	ws a	
	evaluation.				week to ensure the resident a	nd	
					resident representative have b	een	
		note, dated 4/4/25 at 3:41			provided written notice of trans	sfer	
	P.M., indicated amb	oulance staff picked up the			& bed hold policy.		
		cility and transported him to					
		possibility of "trauma from a			The results of these interview	ws	
	fall".				will be reviewed in Quality		
					Assurance Meeting monthly	x6	
		P.M., the Director of Nursing			months or until an average of	I .	
	` ′	e was unable to find the			100% compliance or greater	is	
		for Resident D's transfer to			achieved x3 consecutive		
	acute care on 4/4/25	5.			months. The QA Committee		
					will identify any trends or		
		P.M., the DON provided a			patterns and make		
		charge/Transfer or Resident			recommendations to revise t		
	policy that indicated	d "Complete Transfer Form			plan of correction as indicate	ed.	

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AND PLAN OF CORRECTION IDENTIFICATION NUM		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING D. W.D.G.			(X3) DATE SURVEY COMPLETED	
		155820	B. WI	NG		04/09/	/2025
	PROVIDER OR SUPPLIER			1236 LI	ADDRESS, CITY, STATE, ZIP COD INCOLN AVE SVILLE, IN 47714		
(X4) ID	SUMMARY	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
	Assure required "no resident".	pletely including vital signs otices"are sent with the					
	3.1-12(a)(25)						
	3.1-12(a)(26)						
F 0641 SS=D Bldg. 00	483.20(g) Accuracy of Asses	ssments					
		and record review, the facility	F 06	541	How corrective action will be		05/06/2025
		Minimum Data Set (MDS)			taken for those affected by the	10	
		mpleted accurately for 1 of 1			alleged deficient practice:		
	residents reviewed	for weight loss. (Resident S)			Resident S's MDs has been modified		
	Finding includes:				How will the facility identify other residents having the		
	On 4/4/25 at 12:40	P.M., Resident S's clinical			potential to be affected by th	e	
	record was reviewed	d. Diagnoses included, but			same deficient practice?		
	were not limited to,	dementia, diabetes mellitus,			All residents have the potentia	ıl to	
	and dysphagia.				be affected by the same allege deficient practice.	∍d	
	The most current A	nnual Minimum Data Set			The MDS/CP Coordinator has	,	
	(MDS) Assessment	, dated 2/5/25, indicated			been educated on accurately		
	Resident S had seve	ere cognitive impairment,			completing the MDS assessm	ent	
	required setup assis	tance from staff for eating,			The measures the facility wil	I	
	weighed 179 pound	s (lbs), and had no weight			take or systems the facility w	/ill	
	loss.				alter to ensure that the		
					problem will be corrected an	d	
	`	uarterly MDS Assessment,			will not occur:		
		eated Resident S had severe			The MDS/CP Coordinator has		
		nt, required setup assistance			been educated on accurately		
	_	g, weighed 132 lbs, and had no			completing the MDS assessm	ent.	
	weight loss.				Quality Assurance plans to		
					monitor facility performance		
		ights and vitals tab indicated			make sure that corrections a		
	1	ghed on the following days:			achieved and are permanent		
	- 1/3/25 - 179.3 lbs	_			ADM/Designee will perform 5		
		s wheelchair (a 26.55% weight			reviews a week for 4 weeks, the		
	loss)		1		I 3 times a week for 8 weeks.to		1

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155820		(X2) MULTIPLE C A. BUILDING B. WING	CONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 04/09/2025			
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 1236 LINCOLN AVE EVANSVILLE, IN 47714				
(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 0659 SS=D Bldg. 00	S. The resident weight. 39.5 lbs. CNA 18 complete weighed 123.3 lbs (2/18/25 and a 31.23) On 4/9/25 at 9:19 A indicated that the reshould have been complete with the reshould have been complete with the second MDS Assessment. On 4/9/25 at 12:50 (DON) indicated the Assessment Instrumfor MDS coding. 3.1-31(d) 483.21(b)(3)(ii) Qualified Persons	a.M., CNA 18 weighed Resident ghed 162.8 lbs including the The wheelchair's weight was onfirmed Resident S currently a 6.38% weight loss since % weight loss since 1/3/25). a.M., the MDS Coordinator sident had a weight loss and it oded as such on the Quarterly P.M., the Director of Nursing e facility followed the Resident tent (RAI) Manual as a policy		ensure MDS accuracy The results of these intervie will be reviewed in Quality Assurance Meeting monthly months or until an average of 100% compliance or greater achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise plan of correction as indicate	x6 of is the ed.		
	failed to ensure Qua (QMA) practiced w practice for 2 of 5 runnecessary medica Resident P) Findings include: 1. On 4/7/25 at 12:2 record was reviewed not limited to, type The most recent Ad (MDS) assessment,	riew and interview, the facility alified Medication Aides ithin the QMA scope of esidents reviewed for actions. (Resident U and P. P.M., Resident U's clinical d. Diagnosis included, but was 2 diabetes mellitus. mission Minimum Data Set dated 3/24/25, indicated derately cognitively intact.	F 0659	How corrective action will be taken for those affected by the alleged deficient practice: Resident U has been assessed with no negative outcome. Resident P has been assessed with no negative outcome. QMA's have been educated of QMA Scope of Practice. How will the facility identify other residents having the potential to be affected by the same deficient practice? All residents have the potential be affected by the same alleg deficient practice. QMA's have been educated of	he ed ed on the al to ed		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	00	COMPLETED	
		155820	B. W	ING		04/09/2025	
NAME OF P	DOMDED OF CURPLIES		_	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	<u>C</u>		1236 LI	INCOLN AVE		
APERION	N CARE LINCOLN			EVANS	SVILLE, IN 47714		
(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)		
TAG		LSC IDENTIFYING INFORMATION		TAG		DATE	1
	Physician orders in	cluded, but were not limited to:			QMA Scope of Practice		
					The measures the facility wil		
		minophen (pain medication)			take or systems the facility v	rill	
		ng (milligrams) give one tablet			alter to ensure that the		
		r hours as needed for pain for			problem will be corrected an	d	
	30 days; Start date 3/18/25.				will not occur:		
	The fellowing down in light a OMA administrated				QMA's have been educated o	n tne	
	The following days indicate a QMA administered Hydrocodone-acetaminophen 7.5-325 mg tablet				QMA Scope of Practice.		
					Quality Assurance plans to	.	
	- 3/24/25 7:02 P.M.	rization from a nurse:			monitor facility performance		
					make sure that corrections a		
	- 3/28/25 9:37 A.M.				achieved and are permanent		
	- 3/29/25 3:41 P.M.				DON/Designee will perform 5		
	2. On 4/7/25 at 12:35 P.M., Resident P's clinical record was reviewed. Diagnoses included, but				Medical Records reviews a v		
		_			for 4 weeks, then 3 times a we	ек	
		cerebral palsy, diabetes			for 8 weeks.to ensure QMA's		
	mellitus, and pain.				follow the Scope of Practice		
	The meet exament O	uarterly Minimum Data Set			The results of these interview	vs	
	·	, dated 1/24/25, indicated			will be reviewed in Quality		
	, ,	nitively intact and received			Assurance Meeting monthly		
	-	d during the 7-day look back			months or until an average of		
	period.	d during the 7-day look back			100% compliance or greater achieved x3 consecutive	is	
	period.						
	Current physician o	rders included, but were not			months. The QA Committee will identify any trends or		
	limited to:	racis included, but were not			patterns and make		
		r (a fast-acting insulin) 100			recommendations to revise t	he	
	_	ml) solution - Inject as per			plan of correction as indicate	I	
	sliding scale: 0 - 14	,			plan of correction as maleau	,·	
	141 - 180 = 2;	· ·,					
	181 - 240 = 4;						
	241 - 300 = 6;						
	301 - 350 = 8;						
	351 - 400 = 10;						
	401 - 450 = 12 re-cl	heck in one hour.					
		ore meals and at bedtime					
		mellitus, dated 1/1/25					
		, 					
	- Hydrocodone-acet	taminophen (an opioid pain					
	-	5-325 milligrams (mg) - Give one					

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

PRINTED: 05/06/2025 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155820	(X2) MULTIPL A. BUILDING B. WING	E CONSTRUCTION G 00	COMI	E SURVEY PLETED 9/2025
	ROVIDER OR SUPPLIER		1230	EET ADDRESS, CITY, STATE, ZIP C 6 LINCOLN AVE ANSVILLE, IN 47714	COD	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	CROSS-REFERENCED TO THE	RRECTION HOULD BE APPROPRIATE	(X5) COMPLETION DATE
	tablet by mouth eve for moderate pain, o	ery four hours as needed (PRN) dated 12/31/24.				
	-	taminophen tablet 5-325 mg - mouth every four hours PRN ed 12/31/24				
	Tablet 250-250-65 (Aspirin-Acetamino	nedication) Migraine Oral mg ophen-Caffeine) - Give one ery 24 hours PRN for migraine,				
	Tylenol (a pain medication) Extra Strength Tablet 500 mg - Give two tablets by mouth every eight hours PRN for pain, dated 8/28/23					
	The Medication Ad March and April 20	ministration Record (MAR) for 25 was reviewed.				
		dose				
	3	ed a PRN dose of minophen without prior a nurse on 4/3/25 5:12 P.M.				
		ed a PRN dose of Tylenol rization from a nurse on M.				
	_	minophen without prior a nurse on the following days: M. M.				

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Event ID:

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Facility ID: 000443

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

PRINTED: 05/06/2025 FORM APPROVED OMB NO. 0938-039

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	JLTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPL	LETED
		155820	B. WI	NG		04/09/	/2025
				CTREET A	DDDECC CITY CTATE 7ID COD		
NAME OF F	PROVIDER OR SUPPLIEF	2			ADDRESS, CITY, STATE, ZIP COD NCOLN AVE		
ADEDIO	N CARE LINCOLN				VILLE, IN 47714		
APERIO	N CARE LINCOLIN			EVANS	VILLE, IN 47714		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	- 3/20/25 at 7:03 A.	M.					
	- 3/27/25 at 8:27 A.	M.					
	- 3/31/25 at 6:39 A.M.						
	QMA 15 administered a PRN dose of						
	1 -	minophen without prior					
		a nurse on the following days:					
	- 3/4/25 at 2:58 P.M.						
	- 3/19/25 at 8:18 P.M.						
	- 3/20/25 at 7:21 P.I						
	- 3/21/25 at 7:19 P.M.						
	- 3/24/25 at 8:27 P.M.						
	- 4/4/25 at 7:26 P.M.						
	QMA 15 administered a PRN dose of Excedrin						
	1	rization from a nurse on the					
	following days:	nzation from a nuise on the					
	- 3/6/25 at 8:04 P.M	1					
	- 3/13/25 at 4:00 P.J						
	3/13/23 at 1.001.	171.					
	On 4/8/25 at 9:22 A	A.M., the Director of Nursing					
		at the corporate policy of the					
		w QMAs to administer insulin					
	even if they were in	sulin certified.					
	On 4/9/25 at 9:00 A	a.M., the QMA Scope of					
	Practice was review	ved. It indicated "Administer					
	previously ordered	pro re nata (PRN) medication					
	only if authorization	n is obtained from the facility's					
	licensed nurse on d	uty or on call. If authorization					
	is obtained, the QM	IA must do the following: (A)					
		sident record symptoms					
	I -	for the medication and time					
	the symptoms occurred. (B) Document in the						
	resident record that the facility's licensed nurse						
	was contacted, symptoms were described, and						
	permission was granted to administer the						
		ng the time of contact. (C)					
	_	to administer the medication					
	each time the symp	toms occur in the resident. (D)					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER) 155820		l í	JILDING	nstruction <u>00</u>	(X3) DATE : COMPL 04/09/	ETED	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 1236 LINCOLN AVE EVANSVILLE, IN 47714				
(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 APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
F 0677 SS=E Bldg. 00	the licensed nurse we end of the nurse's shoy the end of the nurse's show the end of the nurse's at 12:14 licurrent QMA job do indicated "EssentialAdministers and do by following specific including oral, topic medications, as well Maintains compliant established communand Federal and Stastandards". 3.1-35(g)(2) 483.24(a)(2) ADL Care Provide Based on observation review, the facility is dependent on staff for living) were shower for 9 of 10 residents (Resident P, Resident Resident B, Resident and Resident U) Findings include: 1. During an intervious each week most we because staff didn't her a bed bath. She they were short staff	l as eye and ear drops ce to all personnel policies, nity policies and procedures,	F 06	677	I. What corrective action(s) wil accomplished for those reside found to have been affected by deficient practice; Resident P has received a short Resident S has received a short Resident D h	onts y the ower ower	05/06/2025

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	00	COMPLI	ETED
		155820	B. W	ING		04/09/2	2025
				CTREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER	L					
ADEDION	LOADELINGOLN				INCOLN AVE		
APERIOR	N CARE LINCOLN			EVANS	SVILLE, IN 47714		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DROVIDED'S DI AN 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)	'E	DATE
	there was no one in	the facility to cut her hair and			be affected by this alleged		
	that her family tried	to fill that role. At that time,			deficient practice.		
	Resident P's hair was observed to be oily. On 4/7/25 at 12:35 P.M., Resident P's clinical				Nursing Staff have been		
					re-educated on the Facility's		
					Bathing Shower and Tub Bath	۱. ا	
		d. Diagnoses included, but					
		cerebral palsy, diabetes			A new Shower Process has be	_{een}	
	mellitus, and major depressive disorder.				implemented.		
	inclination, and major depressive dissider				Implemented:		
	The most current Quarterly Minimum Data Set				Nursing Staff has been educa	ted	
	(MDS) Assessment, dated 1/25/25, indicated				on the New Shower Process.		
	Resident P was cognitively intact and was						
	dependent on staff (staff does all of the effort) for				III. What measures will be put	into	
	bathing and toileting.				place and what systemic chan		
	batting and toneting.				will be made to ensure that the	-	
	The most current ca	re plan conference was			deficient practice does not rec		
		/24. Care plans were reviewed			Nursing Staff have been	u.,	
	and updated at that	-			re-educated on the Facility's		
					Bathing Shower and Tub Bath		
	A current preferenc	es care plan, initiated 2/12/21,			Balling Shewer and Yaz Balli		
	-	P preferred showers twice			A new Shower Process has be	een	
	weekly in the morn	-			implemented.		
	J	5					
	A Point of Care (a o	charting system for CNAs)			Nursing Staff has been educa	ted	
	· ·	rm for showers indicated			on the New Shower Process.		
		d showers on Tuesday and					
	_	owers for the past 30 days			IV. How the corrective action(s	_{s)}	
		wers were not received on the			will be monitored to ensure the	· .	
	following dates:				deficient practice will not recui		
	3/11/25				i.e., what quality assurance		
	3/21/25				program will be put into place;		
					Interdisciplinary Team will		
	2. On 4/3/25 at 11:3	32 A.M., Resident S was			complete 5 resident interviews	sa l	
		n her wheelchair in the			week for 12 weeks to ensure		
		as observed to be disheveled			showers are being provided.		
	and unbrushed. She was noted to smell like urine.				Identified concerns will be		
					addressed timely and discusse	ed	
	On 4/4/25 at 12:40 P.M., Resident S's clinical				in scheduled morning meeting		
		d. Diagnoses included, but			The results of these audits will		
		dementia, repeated falls, and			reviewed in Quality Assurance		
	l	•	1		1		

AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155820		A. BUILDIN B. WING	NG 00	COMP	LETED 0/2025	
	ROVIDER OR SUPPLIER	R	123	REET ADDRESS, CITY, STATE, ZIP COD 36 LINCOLN AVE /ANSVILLE, IN 47714		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFI TAC	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR	ION D BE OPRIATE	(X5) COMPLETION DATE
IAU	major depressive di The most current Q (MDS) Assessment Resident S had seve required substantial staff (staff does mo bathing and toiletin The most current ca completed on 11/14 and updated at that A current preference indicated Resident S week. An ADL care plan, resident needed sub with showers, and i return five to ten may A self care deficit ce indicated to staff to upon rising from na A Point of Care Tas showers indicated F on Tuesday and Fri past 30 days were re received on the follo 3/11/25 3/14/25 3/18/25 3/21/25 received a l 3/25/25 3/28/25	uarterly Minimum Data Set , dated 2/20/25, indicated that ere cognitive impairment and to maximal assistance from re than half of the effort) for g. are plan conference was //24. Care plans were reviewed time. es care plan, initiated 6/16/21, S preferred showers twice a initiated 5/29/24, indicated the estantial to maximal assistance of the resident resisted care, to inutes later and try again. are plan, initiated 6/16/21, perform hair care daily and ap. sks Response Form for Resident P preferred showers day evenings. Showers for the eviewed. Showers were not	IAC	Meeting monthly x6 month until an average of 100 % compliance or greater is a x3 consecutive months. T Committee will identify an or patterns and make recommendations to revision plan of correction as indicated as	chieved he QA y trends e the	DATE
		d she was the last person to				

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155820		A. BU	A. BUILDING 00 B. WING			COMPLETED 04/09/2025	
	ROVIDER OR SUPPLIER	2		1236 LII	DDRESS, CITY, STATE, ZIP COD NCOLN AVE VILLE, IN 47714		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY 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 last person to ge only got bed baths a hair during the bed had just gotten a be washed. At that tim observed to be in a On 4/7/25 at 11:16 record was reviewed were not limited to, and depression. The most current Si Data Set (MDS) As indicated that Residi impairment and was does all of the effort. The most current care completed on 2/27/2 and updated at that A current preference indicated Resident Gweek in the morning. A Point of Care Tas showers indicated Fron Tuesday and The the past 30 days we received on the follow 3/11/25 3/13/25 3/18/25 received a branch side of the same processes and side of the same processes are same processes and side of the same processes and side of the same processes are same processes and side of the same processes and side of the same processes and side of the same processes are same processes and same processes and same processes are same processes and same processes are same processes and same processes are same processes and same proces	es care plan, initiated 2/23/24, G preferred showers twice a g. sks Response Form for Resident P preferred showers tursday day shift. Showers for re reviewed. Showers were not					
	Daring an intervi	on 11.0120 at 2.27 1 .1v1.,					

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155820	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 04/09/2025
	ROVIDER OR SUPPLIER		1236 L	ADDRESS, CITY, STATE, ZIP COD INCOLN AVE SVILLE, IN 47714	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE CY 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 APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	there was no one in residents hair, he cu weeks ago, Resident required staples to l resident received th visited Resident D a He indicated that the	the facility to cut the at Resident D's hair. A few at D had sustained a fall that his head. Five days after the e staples, the family member and attempted to cut his hair. ere was still blood behind his been showered well since the			
	was reviewed. Diag limited to, wedge co	.M., Resident D's clinical record moses included, but were not compression fracture of vertebra and unsteadiness on			
	(MDS) Assessment Resident D had sever required substantial (staff does more that	uarterly Minimum Data Set , dated 2/18/25, indicated ere cognitive impairment, to maximal assistance of staff an half of the effort) for bathing and two or more falls without or assessment.			
		are plan conference was 24. Care plans were reviewed time.			
	_	es care plan, initiated 2/14/24, D preferred showers twice a			
	resident needed sub with showers, and i	initiated 1/27/25, indicated the stantial to maximal assistance f the resident resisted care, to inutes later and try again.			
		sks Response Form for Resident P preferred showers			

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	OF CORRECTION OF CORRECTION 155820	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 04/09/2025
	PROVIDER OR SUPPLIER N CARE LINCOLN	1236 LI	ADDRESS, CITY, STATE, ZIP COD NCOLN AVE VILLE, IN 47714	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	on Monday and Thursday day shift. Showers for the past 30 days were reviewed. Showers were not received on the following dates: 3/10/25 received a bed bath without shampoo 3/13/25 3/20/25 received a bed bath with shampoo 3/24/25 3/27/25 received a bed bath with shampoo 3/31/25 On 4/8/25 at 10:14 A.M., CNA 23 indicated that there was never enough staff to get everything done. 5. On 4/7/25 at 9:24 A.M., Resident B's clinical record was reviewed. Diagnosis included, but was not limited to, hypertensive encephalopathy. The most recent Annual Minimum Data Set assessment, dated 1/3/25, indicated Resident B was moderately cognitively intact, required partial assistance from staff (staff do half of the work) for toileting and transfers, and required substantial assistance for bathing (staff do more than half of the work). Resident B's Activities of Daily Living (ADL) tasks indicated bathing was preferred on Tuesdays and Fridays. During the last 30 days, Resident B did not receive showers during the following dates: 3/11/25 3/21/25 3/25/25 6. On 4/4/25 at 12:48 P.M., Resident N's clinical record was reviewed. Diagnosis included, but was not limited to, diabetes mellitus with diabetic polyneuropathy.			

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	OF CORRECTION	IDENTIFICATION NUMBER 155820	A. BUILDING B. WING	00 00		LETED 0/2025
	PROVIDER OR SUPPLIER		1236 LI	ADDRESS, CITY, STATE, ZIP COD NCOLN AVE SVILLE, IN 47714		
(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 CORRECTI (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	BE	(X5) COMPLETION DATE
	The most recent Qu dated 3/20/25, indic cognitively intact, r from staff (staff do bathing and transfer ulcers, and had no pure Resident N's Activitiasks indicated bath and Thursday. During the last 30 directive showers dura 3/17/25 at 125	arterly MDS assessment, atted Resident N was equired substantial assistance more than half of the work) for rs, was at risk for pressure pressure ulcers. Ities of Daily Living (ADL) ing was received on Monday ays, Resident N did not ring the following dates: TA.M., Resident F's clinical d. Diagnosis included, but was retension. arterly MDS assessment, atted Resident F was equired partial assistance work) for showers and the for transfers to the shower. ies of Daily Living (ADL) ing was preferred on Monday ays, Resident F did not receive				

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

PRINTED: 05/06/2025 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155820		A. BUILDI B. WING		00	COMPL 04/09/	ETED	
	PROVIDER OR SUPPLIER	2	12	36 LII	ADDRESS, CITY, STATE, ZIP COD NCOLN AVE VILLE, IN 47714		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREF TA		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
TAG	8. During an observer Resident L's hair aptingernails were lor L indicated she had admission. On 4/7/25 at 8:55 A was reviewed. Resident L's Diagnosis to, malignant neoplement of the most recent Admission (MDS) assessment, Resident L was cogpartial assistance (stoileting and bathin Resident L's Activitation to the state of the	ration on 4/4/25 at 8:59 A.M., ppeared unkempt and her ag and yellow tinged. Resident not had her hair washed since a.M., Resident L's clinical record dent L was admitted on included, but was not limited asm. Imission Minimum Data Set dated 3/25/25, indicated nitively intact and required taff do half of the work) for g. Ities of Daily Living (ADL) ident L had zero days impoo during bathing since 29 P.M., Resident U's clinical d. Resident U was admitted on included, but was not limited	TA	G			DATE
	required partial assi least half of the wor Resident U's Activi	stance for transfers (staff do at					
	l						

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Facility ID: 000443

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155820		(X2) MULTIPLE C A. BUILDING B. WING	<u></u>				
	PROVIDER OR SUPPLIER		1236 L	ADDRESS, CITY, STATE, ZIP COD LINCOLN AVE SVILLE, IN 47714	1 2 3 3 3 3 3		
(X4) ID PREFIX			ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE COOSE DEFEDERACE) TO THE ADDRODDE			
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE		
	_	lays, Resident U did not ring the following dates:					
	Director of Nursing interdisciplinary tea showers not being g concern and indicat person in charge of	y on 4/9/25 at 10:14 A.M., the (DON) indicated the am was aware ADL's such as given were an ongoing ed there was not a specific making sure showers were L's not being performed was an g the last year.					
	policy titled Bathing revised 1/18, that in or bed/sponge bath resident's preference	P.M., the DON provided a g Shower and Tub Bath, idicated "A shower, tub bath will be offered according to es two times per week or ident's preferred frequency quested."					
	This citation relates Complaint IN00449	to Complaint IN00456840 and 0780.					
	3.1-38(a)(3)						
F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to	o Prevent/Heal Pressure					
5	potential for the dev perform routine skin of care to promote v	, record review, and ility failed to identify the velopment of pressure ulcers, n checks, and follow the plan wound healing for 2 of 2 for facility acquired heel	F 0686	What corrective actions hav been accomplished for thos residents found to have bee affected by the deficient practice. Resident N has had a ski	e n		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u>			COMPLETED	
		155820	B. WING 04/09/2025			2025	
		1	<u> </u>	STREET 4	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER	R			NCOLN AVE		
APFRION	N CARE LINCOLN				VILLE, IN 47714		
	. C. IIICOLIN						
(X4) ID		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 APPROPRIATE		TE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	wounds. (Resident l	r, Kesident F)			assessment completed		
	F' 1' ' 1 1				Resident N's Care Plan h		
	Findings include:				been updated to include an at		
	1.50	4/4/25 4 2 20 D M			for pressure ulcer developmer		
	_	iew on 4/4/25 at 2:29 P.M.,			Resident F's treatment ha	IS	
		served to have a wound vac (a			been administered		
		uses negative pressure to aling) on his right heel.			Resident F's Care Plan ha		
	*	on his right neel. It is started out as a blister and			been updated to include an at		
		quiring surgical debridement			for pressure ulcer developmer	11.	
		sident N indicated the wound			Llow the feeility will identify		
	_	ring in the facility longer than			How the facility will identify		
	anticipated.	ing in the facility longer than			other residents having the potential to be affected by th	_	
	anticipated.				same deficient practice:	е	
	On 4/4/25 at 12:48	P.M., Resident N's clinical			same dencient practice.		
		d. Resident N was admitted on			All residents with pressure	<u> </u>	
		y following a recent fracture	All residents with pressure ulcer or potential for pressure				
		included, but was not limited			ulcers have the potential to be		
	to, diabetes mellitus				affected by the alleged deficie		
	polyneuropathy.	with diabetic			practice.	111	
	perjinear epainty.				Nursing staff have been		
	An Admission Mini	imum Data Set (MDS)			educated on the Facility's		
		2/29/24, indicated Resident N			pressure ulcer prevention police	CV.	
		act, required partial assistance			the Facility's Pressure ulcer po	-	
		If of the work) to roll left to			including completing weekly sl	-	
		tantial assistance (staff do			assessments.		
		ne work) for bathing, transfers,					
		ng off footwear, and			A complete Skin		
	-	ll hygiene, and was at risk for			Assessment has been comple	ted	
	pressure ulcers but	had no pressure ulcers.			on residents, with Physician		
					notification completed on any	new	
	The clinical record	lacked a comprehensive care			skin impairment identified, any	,	
	plan related to Resid	dent N's risk for pressure ulcer			new orders followed, a new th	е	
	development.				Plan of Care reviewed and up	dated	
					accordingly.		
	The clinical record	lacked weekly skin					
	observations from 1	1/29/24 to 1/8/25.			MDS/CP Coordinator has		
					been educated on implementa	ition	
		ervation, dated 1/8/25 at 2:49			of "At Risk "Care Plans" as		
	P.M., indicated Res	ident N had a skin concern of			appropriate.		
	1		1				

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>00</u>		COMPLETED	
		155820	B. W	ING		04/09/	2025
		<u> </u>		CTDEET	ADDRESS CITY STATE ZID COD		
NAME OF P	ROVIDER OR SUPPLIEF	8	STREET ADDRESS, CITY, STATE, ZIP COD 1236 LINCOLN AVE				
∧ DEDION	A CADE LINICOLNI						
AFERION	N CARE LINCOLN			EVAINS	SVILLE, IN 47714		
(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	ATE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	the pressure injury to the right heel and "skin						
	concerns observed are not new."						
					Measures the facility will tak	(e	
	_	rt, dated 1/8/25, indicated			to ensure that the problem v	vill	
		reloped a new in-house			be corrected and will not rec	cur:	
		njury to the right heel.					
		ne wound were: length 6 cm			Nursing staff have been		
		18 cm, and depth 0.2 cm, and			educated on the Facility's		
	staging was left bla	nk.			pressure ulcer prevention poli	icy,	
					the Facility's Pressure ulcer p	olicy	
		was started on 1/9/25 for			including completing weekly s	skin	
	ascorbic acid 500 mg (milligrams) tablet give one				assessments.		
	-	e time a day for wound healing,					
	and was discontinue	ed on 1/23/25.			A complete Skin		
					Assessment has been comple	eted	
		vas started on 1/9/25 that		on residents, with Physician			
		area with wound cleanser and			notification completed on any		
		eri-wound area and allow to			skin impairment identified, an		
		ver wound bed with honey			new orders followed, a new th		
		wound dressing that combines			Plan of Care reviewed and up	dated	
		ney and calcium alginate,			accordingly.		
		wound fluid, forming a gel					
		a moist environment			MDS/CP Coordinator has		
		g and potentially supporting			been educated on implementa	ation	
		otic tissue), cover with ABD			of "At Risk "Care Plans" as		
		d wrap with Kerlix (gauze wrap)			appropriate.		
		pressure injury to right heel,					
	and was discontinue	ed on 1/23/25.			Quality assurance plans to		
		1 . 11/12/25 : 1: . 1			monitor facility performance		
		n, dated 1/13/25, indicated			make sure that corrections a		
		neel wound was an unstageable			achieved and are permanent	t:	
		e injury. The evaluation			DON'S : :: :		
	indicated to float th	e residents heels.			DON/Designee will perform		
		1/10/05 40 00 P.15			Medical Record Reviews 5 tin		
		note on 1/18/25 at 9:09 P.M.,			week for 4 weeks, then 3 time	es a	
		N was sent to the hospital for			week for 8 weeks to ensure		
	coffee ground emes	SIS.			weekly skin assessments are		
	2.5.	4/7/05 + 10.50 + 3.5			completed.		
	2. During an intervi	iew on 4/7/25 at 10:59 A.M.,	ı		1		

Resident F indicated that he was admitted for

DON/Designee will perform

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155820		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 04/09/2025	
	ROVIDER OR SUPPLIER		1236 L	ADDRESS, CITY, STATE, ZIP COD INCOLN AVE SVILLE, IN 47714	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION bk but stayed at the facility due	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) Medical Record Reviews 5 tin	DATE
	healed yet due to th	foot, and he believed was not e dressing not being changed. A.M., Resident F's clinical		week for 4 weeks, then 3 time week for 8 weeks to ensure P of Care is updated accordingl The results of these aud	lan y.
	record was reviewe	d. Resident F was admitted on sincluded, but was not limited		will be reviewed in Quality Assurance Meeting monthly x3months or until an averag of 100 % compliance or	
	indicated Resident l dependent (staff do	S assessment, dated 11/26/24, F was cognitively intact, was all of the work) for putting on		greater is achieved x3 consecutive months. The Q Committee will identify any	
	assistance from staf the work) for bathir partial assistance (s	vear, required substantial If (staff do more than half of and transfers, required taff do at least half of the		trends or patterns and make recommendations to revise plan of correction as indicate	the
	ulcers, and had no u	right, was at risk for pressure inhealed pressure ulcers. t, dated 12/18/24, indicated			
	acquired pressure ir Measurements of th	eloped a new in-house ajury to the left heel. e wound were: length 2.5 cm a 7 cm, and was a deep tissue			
	A care plan was cre	ated on 12/19/24 and indicated jury to my left heel related to			
		d at risk for developing skin ing prior to pressure ulcer			
	indicated cleanse ar cleanser, gently pat peri-wound area and apply honey impreg	vas started on 1/3/25 that ea (left heel) with wound dry, apply skin prep d allow to completely dry, mated calcium alginate to er with ABD (abdominal) pad			

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155820	r í	JILDING	nstruction <u>00</u>	(X3) DATE : COMPL 04/09/	ETED
	PROVIDER OR SUPPLIER		•	1236 LII	ADDRESS, CITY, STATE, ZIP COD NCOLN AVE VILLE, IN 47714		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION ix (gauze wrap) every day shift		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	for pressure injury t discontinued on 1/1	to left heel, and was					
	administration reco	rd (TAR) indicated Resident t was not changed and was					
	Resident F had beer was using the parall ulcer and unable to						
	indicated cleanse ar cleanser, gently pat peri-wound area and apply honey alginat ABD pad, wrap wit medical tape, every	vas started on 1/21/25 that rea (left heel) with wound dry, apply skin prep d allow to completely dry, se to wound bed, cover with the Kerlix and secure with day shift for pressure injury to iscontinued on 1/28/25.					
	administration reco	s in the electronic treatment rd (TAR) indicated Resident t was not changed and was					
	indicated cleanse ar cleanser, gently pat wound area and allo area with betadine a ABD pad, wrap wit medical tape every	vas started on 1/29/25 that rea (left heel) with wound dry. Apply skin prep perious to completely dry. Paint and allow to dry, cover with h Kerlix and secure with day shift for pressure injury to iscontinued on 2/24/25.					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA				NSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 00 COMPLETED				
		155820	B. W	ING		04/09/	/2025
	PROVIDER OR SUPPLIER		•	1236 LII	DDRESS, CITY, STATE, ZIP COD NCOLN AVE VILLE, IN 47714		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DDOWINED'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
	administration recor F's wound treatmen not refused: 2/7/25 2/8/25 2/14/25 2/21/25 The most recent Qu dated 2/17/25, indic cognitively intact, re (staff do half of the on and taking off for assistance for transf for pressure ulcers, pressure ulcers, pressure ulcer. A treatment order w indicated cleanse ar cleanser, gently pat peri-wound area and to fit honey alginate cover with ABD pawith medical tape, a 3/17/25. The following dates administration recor F's wound treatmen not refused: 3/4/25 3/9/25 A medication order indicated cephalexin (milligrams) give on	s in the electronic treatment rd (TAR) indicated Resident t was not changed and was earterly MDS assessment, eated Resident F was equired partial assistance work) for showers and putting not wear, and substantial fers to the shower, was at risk and had an unstageable evas started on 2/25/25 that rea (left heel) with wound dry, apply skin prep d allow to completely dry, cut e and place in wound bed, d, wrap with Kerlix and secure and was discontinued on s in the electronic treatment rd (TAR) indicated Resident t was not changed and was was started on 3/12/25 that in (antibiotic) capsule 500 MG ine capsule by mouth three it wound) infection for 10 days, ed on 3/22/25.					

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PRINTED: 05/06/2025 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155820		(X2) MULTIPLE (A. BUILDING B. WING	construction <u>00</u>	COMI	(X3) DATE SURVEY COMPLETED 04/09/2025	
	PROVIDER OR SUPPLIE N CARE LINCOLN	R	1236	TADDRESS, CITY, STATE, ZIP CO LINCOLN AVE ISVILLE, IN 47714	DD .	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	indicated cleanse a cleanser, gently par wound area and all layer of Manuka H calcium alginate ov Hydra Lock dressir with Kerlix and seed day shift for pressure discontinued on 3/3. The following date administration recorder of the following date administration recorder wound treatment or refused: 3/21/25 A treatment order of indicated enhanced wear gown and gloresident care activition right heel. The most recent words 3/31/25, indicated measured 2 cm length depth. A treatment order of indicated cleanse a cleanser, gently parallow to completely HydraLock (an abscover with ABD (a (gauze bandage), a every day shift for	was started on 3/18/25 that rea (left heel) with wound a dry, apply skin prep periow to completely dry, apply oney to wound bed, place wer wound bed, cover with ag, cover with ABD pad, wrap are with medical tape, every re injury to left heel, and was 31/25. Is in the electronic treatment and (TAR) indicated Resident at was not changed and was Was started on 3/31/25 that barrier precautions: staff to ves during all high contact ties every shift for surgical site Figure 1 and 1 an				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155820		(X2) MULTIPLE C A. BUILDING B. WING				
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 1236 LINCOLN AVE EVANSVILLE, IN 47714			
(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	
	4/1/25 4/8/25 During an interview Director of Nursing be following physic During an observati Resident F was obset 4/7, around his left of 1/25 at 12:14 policy titled Pressur 1/15/18, indicated pressure sores/ presclean/dry skin inspecially. Use positioning the property of the pressure of the pressure of the pressure sores of	t was not changed or refused: or on 4/8/25 at 1:23 P.M. the (DON) indicated staff should ian's orders as written. on on 4/9/25 at 11:40 A.M., erved with a dressing, dated foot. P.M., the DON provided a re Ulcer Prevention, revised The purpose: to prevent sure injury. Maintain sect the skin several times and devices to reduce supplements as ordered".				
F 0689 SS=D Bldg. 00	3.1-40(a)(1) 483.25(d)(1)(2) Free of Accident Hazards/Supervisi Based on observation review, the facility of revise care plans, and reduce the risk of factive reviewed for falls. (Findings include: 1. During a confidence survey, it was indicated a lot while attemption	to complaint IN00456840. Jon/Devices Jon, interview, and record failed to follow fall protocol, and follow interventions to and follow interventions to and Resident S Resident D and Resident S) Intial interview during the atted that Resident D had fallen and to self toilet because when aght no one came to help him	F 0689	How corrective action will be taken for those affected by the alleged deficient practice: Resident D's Fall interventions have been implemented Resident D's Plan of Care has been reviewed and update accordingly Resident S's Fall interventions have been implemented. Resident S's Plan of Care has been implemented.	ne do not 2020	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLETED	
		155820	B. W	ING		04/09/2025	
				STREET	ADDRESS, CITY, STATE, ZIP COD	1	
NAME OF F	PROVIDER OR SUPPLIER	8			INCOLN AVE		
APERIO	N CARE LINCOLN				SVILLE, IN 47714		
	T	OT A TEMPLIT OF DEPOSITS OF			, T	OTE:	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (FACH CORRECTIVE ACTION SHOULD BE	(X5)	
TAG	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION	
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION	+	TAG		DATE	
	On 4/4/25 at 1:26 P.M., Resident D was observed				has been reviewed and updat	eu	
		h his wheelchair in his room			accordingly. How will the facility identify		
		nt was wrapped around the bed			other residents having the		
		oped to or within reach of the			potential to be affected by the	10	
		not a dycem in his wheelchair.			same deficient practice?		
		earing socks without nonskid			All residents have the		
		strips were not observed			potential to be affected by the		
	anywhere in the res				same deficient practice.		
	,				Nursing staff have been		
	On 4/7/25 at 2:40 P.M., Resident D's clinical record				educated on the Facility's Fall		
	was reviewed. Diagnoses included, but were not				Protocol, including following		
	limited to, dementia, epileptic seizures, wedge				interventions.		
	compression fracture of unspecified lumbar				MDS/CP Coordinator has	i	
	1 -	alls, unsteadiness on feet, and			been educated on Revision of	the	
	weakness.				Care Plans with Fall interventi		
					The measures the facility wil	ı	
	The most recent Qu	arterly Minimum Data Set			take or systems the facility v		
	(MDS) Assessment	, dated 2/18/25, indicated			alter to ensure that the		
	Resident D had seve	ere cognitive impairment,			problem will be corrected an	d	
	required substantial	to maximal assistance of staff			will not occur:		
	(staff does more that	in half of the effort) for			Nursing staff have been educate	ated	
		nd transferring, and had 2 or			on the Facility's Fall Protocol,		
	more falls without i	njury since the prior			including following intervention	ns.	
	assessment on 1/6/2	25.			MDS/CP Coordinator has bee	n	
					educated on Revision of the C	Care	
		onference was completed on			Plans with Fall interventions.		
		were reviewed and updated at			Quality Assurance plans to		
	that time.				monitor facility performance		
					make sure that corrections a		
	_	risk care plan, initiated 2/17/24,			achieved and are permanent	:	
	included the follow	_			DON/Designee will perform 5		
	_	t residents needs, dated			observations a week for 4 week		
	2/17/24				then 3 times a week for 8 wee		
		all light is within reach and			of Fall interventions to ensure		
		to use it for assistance as			implementation.		
		nt needs prompt response to			DON/Designee will perform 4	-1. f- :-	
	all requests for assis				Medical Record reviews a week		
		t is wearing appropriate			4 weeks, then 3 times a week	TOT	
1	ı Tootwear when amb	outaing or modifizing in wheel			8 weeks to ensure Fall	l l	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155820		(X2) MULTIPLE (A. BUILDING B. WING	construction <u>00</u>	(X3) DATE SURVEY COMPLETED 04/09/2025			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 1236 LINCOLN AVE EVANSVILLE, IN 47714				
(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		
	chair, dated 2/17/24 Follow facility fall p 2/17/24 Notify family and p 2/17/24 Physical Therapy (F (OT) evaluations an as needed (PRN), da The resident needs a potential for falls w distraction, dated 2/ Resident placed on an early riser, dated Call light clip place educated to clip call chair so resident can 3/24/24 Ensure resident is to to bed, dated 4/21/2 Anti-rollbacks to w Anti-tippers to whee "Call, Don't Fall" si as reminder for him get up unassisted, d Dycem to wheelcha Fall mat to be place dated 6/25/24 Reach out to Medic aide, dated 6/29/24 Offer sleep aide, da Staff to offer reside after lunch, dated 7/ Therapy to adjust an wheelchair, dated 7/ Resident is not to be wheelchair unattence Re-educate nursing left alone in room a	brotocol if fall occurs, dated hysician of all falls, dated PT) and Occupational Therapy d treatments as ordered and ated 2/17/24 activities that minimize the hile providing diversion and 17/24 night shift get up list as he is 3/5/24 d on call light and staff light to resident clothes or n easily find call light, dated bileted prior to resident going 4 heelchair, dated 6/8/24 elchair, dated 6/11/24 gns in room and in bathroom to call before he attempts to ated 6/19/24 ir, dated 6/23/24 d at bedside when he is in bed, al Doctor (MD) for a sleep ted 6/29/24 nt assistance to recliner to rest 15/24 eleft in his room in his led, dated 8/6/24 staff that resident is not to be lone in wheelchair, dated 9/9/24 bileted before and after each		interventions are updated on the Care Plan. The results of these interviewill be reviewed in Quality Assurance Meeting monthly months or until an average of 100% compliance or greater achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise to plan of correction as indicated.	he ws x6 uf is		

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

PRINTED: 05/06/2025 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155820		A. BUIL	A. BUILDING 00 B. WING			COMPLETED 04/09/2025	
	PROVIDER OR SUPPLIER	t		1236 LIN	DDRESS, CITY, STATE, ZIP COD NCOLN AVE /ILLE, IN 47714		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	be left alone in roon 11/27/24 Keep personal belowersident, dated 1/6/25 Staff to encourage in hight instead of recipient instead of instead in the past year in the past yea	resident to sleep in his bed at liner, dated 1/23/25 gn placed in public restroom rest floor, dated 2/3/25 greed on bed to prevent resident bed while sleeping, dated greed while sleeping, dated greed while sleeping, dated greed					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155820		A. BUILDING 00 COMPLETED B. WING 04/09/2025			ETED		
NAME OF P	ROVIDER OR SUPPLIER	- {			DDRESS, CITY, STATE, ZIP COD		
APERION	N CARE LINCOLN				NCOLN AVE VILLE, IN 47714		
(X4) ID		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' DEFICIENCY)	ΓE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION lacked an IDT note about that		TAG	DEFICIENCE		DATE
	fall.	lacked an ID1 note about that					
		not updated with a new					
	intervention.	iot apaatea with a new					
	A fall risk assessme	ent was not completed.					
	Fall 3 On 6/8/24 at 8:25 A unwitnessed fall wh door in his room. The IDT reviewed t "Anti-rollbacks to v care plan. A fall risk assessme Resident D was at h Fall 4 On 6/11/24 at 8:09 unwitnessed fall wh was found lying on his wheelchair. The IDT reviewed t "Anti-tippers to wh care plan.	a.M., Resident D had an nile attempting to close the that fall on 6/11/24. wheelchair" was added to the ent, dated 6/8/24, indicated high risk for falls. P.M., Resident D had an nile attempting to self toilet. He his bathroom floor in front of					
	Fall 5 On 6/12/24 at 1:42 unwitnessed fall wh was found sitting or The physician and r notified about that f The clinical record fall. The care plan was r intervention. A fall risk assessment	A.M., Resident D had an nile attempting to self toilet. He n the bathroom floor.					
	Fall 6 On 6/19/24 at 10:35	5 A.M., Resident D had an					

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	of correction (X1) provider/supplier/clia (IDENTIFICATION NUMBER (155820)	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 04/09/2025
	PROVIDER OR SUPPLIER	1236 LI	ADDRESS, CITY, STATE, ZIP COD NCOLN AVE VILLE, IN 47714	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	unwitnessed fall while attempting to self toilet. A CNA responded to a call light in the resident's room and found the resident lying on the floor on his right side with his feet towards the door of the bathroom. The resident complained of bilateral hip pain. The physician was notified, and an order was received for an x-ray of the hip and pelvis. The results of that x-ray were negative. The IDT reviewed that fall on 6/21/24. "Call, Don't Fall signs in room and in bathroom as reminder for him to call before he attempts to get up unassisted" was added to the care plan. A fall risk assessment, dated 6/19/24, indicated Resident D was at high risk for falls. Fall 7 On 6/23/24 at 8:35 A.M., Resident D had an unwitnessed fall while in his room. The resident was found on his knees on the floor in front of his bed. The clinical record lacked an IDT note about that fall. The care plan was not updated with a new intervention. A fall risk assessment, dated 6/23/24, indicated Resident D was at high risk for falls. Fall 8 On 6/23/24 at 12:25 P.M., Resident D had an unwitnessed fall while in his room. A visitor alerted the nurse that the resident was lying on the floor in his room. The resident was noted to have a two inch by one inch bruised area on the top right side of his head. The physician was notified, and an order was received to send the resident to the hospital for evaluation. The resident returned to the facility from the hospital at 7:05 P.M. A computed tomography (CT) scan (a medical imaging technique used to obtain detailed internal images of the body)			

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155820	, ,	LDING	nstruction <u>00</u>	(X3) DATE : COMPL 04/09/	ETED
	PROVIDER OR SUPPLIER			1236 LI	DDRESS, CITY, STATE, ZIP COD NCOLN AVE VILLE, IN 47714		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	I	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
IAG	indicated there were recent falls; however fracture had gotten The clinical record fall. "Dycem to wheelch on 6/23/24. A fall risk assessmer Resident D was at he fall on 6/25/24 at 10:16 unwitnessed fall in found lying on the fall wheelchair. The IDT reviewed to be placed at bedside added to the care placed at bedside added to the care placed at health of the fall risk assessmer Resident D was at he fall risk assessmer Resident D was at he fall to on 6/29/24 at 10:34 unwitnessed fall who was found on the floor found on the floor found on the floor found on 6/30/24 for bacitracin ointer the found on 6/30/24 for bacitracin ointer the found on the floor found on 6/30/24 for bacitracin ointer the found on 6/30/24 for bacitracin ointer the floor found of the floor	e no new injuries related to er, the resident's chronic back worse. lacked an IDT note about that hair" was added to the care plan ent, dated 6/23/24, indicated high risk for falls. 6 A.M., Resident D had an his room. The resident was floor between his bed and that fall on 6/26/24. "Fall mat to e when he is in bed" was an. ent, dated 6/25/24, indicated high risk for falls. 4 P.M., Resident D had an hile in his room. The resident or next to his bed. He knee pain. The physician was er was received to send the ital for evaluation. ed to the facility from the at 5:15 A.M. with a new order nent to the abrasion on his right reven days. No other injuries that fall on 7/1/24. "Reach out fall o		IAU			DATE
	received on 7/3/24.						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155820		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 04/09/2025	
	PROVIDER OR SUPPLIER		1236 LI	ADDRESS, CITY, STATE, ZIP COD INCOLN AVE SVILLE, IN 47714	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION ent was not completed.	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE COMPLETION
	Fall 11 On 7/4/24 at 3:30 P unwitnessed fall wholed. The resident woof his bed. The clinical record fall. "Staff to offer residurest after lunch" wa A fall risk assessme Resident D was at he fall 12 On 7/15/24 at 2:30 witnessed fall while in the hallway. The resident fell and hit The clinical record fall. "Therapy to adjust a wheelchair" was ad 7/15/24. A fall risk assessme Resident D was at he fall 13 On 8/6/24 at 11:17 unwitnessed fall whole something up off the found lying on the froom. The IDT reviewed to not to be left in his sunattended" was ad	a.M., Resident D had an ille attempting to put himself to as found on the floor in front lacked an IDT note about that ent assistance to recliner to a added to the care plan. Int, dated 7/4/24, indicated high risk for falls. P.M., Resident D had a strying to get up using the rail wheelchair moved and the the back of his head. Lacked an IDT note about that lanti-rollbacks on resident's ded to the care plan on the entry of the entr			

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		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLETED		
		155820	B. W	ING		04/09/	/2025	
	PROVIDER OR SUPPLIER	2	•	STREET ADDRESS, CITY, STATE, ZIP COD 1236 LINCOLN AVE EVANSVILLE, IN 47714				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID			(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	.TE	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	NIE	DATE	
	On 8/14/24 at 2:00	A.M., Resident D had an						
	unwitnessed fall in his room. He was found lying							
	on his fall mat. The clinical record lacked an IDT note about that fall.							
	The care plan was r	not updated with a new						
	intervention.							
	A fall risk assessment, dated 8/14/24, indicated							
	Resident D was at h	nigh risk for falls.						
	Fell 15							
	Fall 15 On 8/19/24 at 2:09 P.M., Resident D had an							
	unwitnessed fall while attempting to self toilet. A							
		the resident's call light and						
		gainst the wall next to the						
	toilet.	gamst the wan heat to the						
		lacked an IDT note about that						
	fall.							
		not updated with a new						
	intervention.	•						
	A fall risk assessme	ent, dated 8/21/24, indicated						
	Resident D was at l	nigh risk for falls.						
	Fall 16							
		15 A.M., Resident D had an						
		nile attempting to self toilet. A						
	_	an emergency call light in the						
	· ·	and found the resident lying on						
		or next to the toilet with his						
		ide. The resident was noted to						
		e left side of his forehead. that fall on 11/25/24. "Ensure						
	resident is toileted before and after each meal" was added to the care plan.							
		ent, dated 11/24/25, indicated						
	Resident D was at h							
	Tiesiaent B was at 1							
	Fall 17							
		2 P.M., Resident D had an						
	unwitnessed fall while attempting to self toilet.							

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155820		(X2) MULTIPLE CO A. BUILDING B. WING			
NAME OF F	PROVIDER OR SUPPLIEF			ADDRESS, CITY, STATE, ZIP COD	•
APERION	N CARE LINCOLN			SVILLE, IN 47714	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL	D BE COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPR DEFICIENCY)	OPRIATE DATE
		und sitting on the floor			
	between the toilet a	that fall on 12/3/24. "Reinforce			
		resident is not to be left alone			
	_	neelchair" was added to the			
	care plan.				
		ent, dated 11/27/24, indicated			
	Resident D was at h	nigh risk for falls.			
	Fall 18				
	On 12/27/24 at 4:30 P.M., Resident D had an unwitnessed fall while attempting to throw an item away. The resident was found sitting upright on the floor next to his recliner.				
		that fall on 12/31/24. The new			
		ined at that meeting was to			
		in front of the resident's			
	recliner.				
	The care plan was r	not updated with a new			
	intervention.	•			
	A fall risk assessme	ent, dated 12/27/24, indicated			
	Resident D was at h	nigh risk for falls.			
	Fall 19				
		.M., Resident D had an			
		nile attempting to walk to get a			
		in the corner of his room. The			
		lying on the floor on his back			
		air. The resident complained of domen. The physician was			
	notified.	iomen. The physician was			
		.M., an order was received for			
		acic spine right side rib due to			
	pain after the fall.				
	1 ~	pleted on 1/8/25. Results were			
	negative and there				
		that fall on 1/9/25. "Keep			
		s within reach of resident" was			
	added to the care pl				
	A fall risk assessme	ent, dated 1/9/25, indicated			

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155820		A. BUILDING B. WING	COMPLETED 04/09/2025		
	PROVIDER OR SUPPLIER		1236 LI	ADDRESS, CITY, STATE, ZIP COD NCOLN AVE VILLE, IN 47714	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION igh risk for falls.	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE COMPLETION
	unwitnessed fall wh from his recliner to was found lying on of his recliner. The IDT reviewed to encourage resident instead of recliner. A fall risk assessme Resident D was at he can be compared to a bathroom. The resident purpose of the IDT reviewed to the IDT reviewed to the IDT reviewed to a bathroom. The resident D was at he can be compared to a bathroom of the IDT reviewed to a bathroom of the IDT reviewed to Fall sign placed in promise of the IDT reviewed to Fall sign placed in promise of the IDT reviewed to send the IDT reviewed to	a.M., Resident D had an ile attempting to self toilet. A a call light in the hallway lent was found lying on the oilet. that fall on 2/5/25. "Call, Don't oublic restroom next to pantry dded to the care plan. nt, dated 2/3/25, indicated igh risk for falls. A.M., Resident D had an his room. The resident was netween his bed and the exercise resident was noted to have exact on the back of his head are amount of blood on the a was notified, and an order d the resident to the hospital			

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AND PLAN OF CORRECTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155820		A. BUILDING 00 COMPLET B. WING 04/09/20			ETED		
	ROVIDER OR SUPPLIER	t	12	236 LIN	DDRESS, CITY, STATE, ZIP COD NCOLN AVE VILLE, IN 47714		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	II PRE TA		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ē	(X5) COMPLETION DATE
	rolling out of bed w	bed to prevent resident from thile sleeping" was added to ent, dated 3/10/25, indicated high risk for falls.					
	indicated Resident I note did not indicate took place. The clinical record regarding the fall the Clinical record indicate the physici notified of that fall. The clinical record fall. The care plan was reintervention. A fall risk assessment A nursing progress A.M., indicated that	note, dated 4/3/25 at 6:53 P.M., D was assessed for a fall. The e when, where, or how the fall lacked documentation nat took place on 4/3/25. lacked documentation to an and responsible party were lacked an IDT note about that not updated with a new ent was not completed. note, dated 4/4/25 at 9:17 t the resident was not acting s unable to stand up and					
	complained of pain	to his left hip, left arm, left ank. The physician was					
	A.M., indicated that facility and assessed	note, dated 4/4/25 at 10:47 t the physician was in the d the resident. Orders for x-ray of the left shoulder and ed.					
		note, dated 4/4/25 at 2:13 resident was hallucinating.					
		note, dated 4/4/25 at 3:10 ew order was received to send					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155820		A. BU	A. BUILDING 00 COMPL B. WING 04/09/				
	ROVIDER OR SUPPLIER	t		1236 LIN	DDRESS, CITY, STATE, ZIP COD NCOLN AVE VILLE, IN 47714		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY 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 APPROPRI TAG DEFICIENCY)		ΓE	(X5) COMPLETION DATE
	the resident to the hevaluation.	ospital for treatment and					
	P.M., indicated amb	note, dated 4/4/25 at 3:41 bulance staff picked up the cility and transported him to possibility of "trauma from a					
	indicated the CT sc injury or fracture, u and blood workup v	paperwork, dated 4/4/25, an was negative for acute rinalysis was negative for UTI, was unremarkable. The resident hospital for evaluation of my.					
	that the resident wa medication for seize and because there v findings, a new anti	sy note, dated 4/7/25, indicated s on anticonvulsant ures prior to his hospitalization were no other remarkable convulsant medication would t to address the mental and					
	record was reviewe	40 P.M., Resident S's clinical d. Diagnoses included, but dementia, muscle weakness,					
	(MDS) Assessment Resident S had sever required partial to re (staff does less than transferring, require assistance of staff (state of the effort) for toilet or more falls since	inual Minimum Data Set , dated 2/5/25, indicated ere cognitive impairment, moderate assistance of staff a half of the effort) for ed substantial to maximal staff does more than half of ing and bathing, and had two the prior assessment.					
	The last care plan c	onference was completed on					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLETED	
		155820	B. W	ING		04/09/	/2025
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIER	8			NCOLN AVE		
∧DEDI∩!	N CARE LINCOLN				VILLE, IN 47714		
AFERIO	N CARE LINCOLN			EVAINS	VILLE, IN 477 14		
(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	ΓF	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	11/14/24. Care plan	s were reviewed and updated.					
A current increased risk for falls care plan,							
	initiated 6/16/21, included the following						
	interventions:						
	Anticipate and mee	t residents needs, dated					
	6/16/21						
	Be sure residents ca	all light is visible and within					
	reach. The resident	needs prompt response to all					
	requests for assistar	nce, dated 6/16/21					
	Follow facility fall	protocol if fall occurs, dated					
	6/16/21						
	Notify family and p	hysician of all falls, dated					
	6/16/21						
	Nursing to check or	n resident every hour					
	throughout the nigh	-					
		Fall" sign within view of					
	resident's recliner, d	•					
		istance with showers" sign in					
	bathroom, dated 3/1	_					
	· ·	cleaning and tidying up her					
	1	all" sign replaced and resident					
		e it up as a reminder, dated					
	3/16/22						
	Move resident to ro	om closer to nurses station for					
	closer observation,						
		ng/shower/hygiene needs an					
	hour prior to dinner						
		PT) and Occupational Therapy					
		ng positioning in recliner;					
	replace recliner, dat						
		shower entry, dated 4/24/22					
	_	ileting prior to lunch, dated					
	4/24/22						
		d assist resident with toileting					
	needs prior to break	——————————————————————————————————————					
		get resident monthly weights,					
	dated 6/2/22	52. 1301done monemy worging,					
		nsfers/positioning, dated					
	8/26/22	positioning, utility					
	5. 2 6. 2 6						

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	of correction (X1) provider/supplier/clia (IDENTIFICATION NUMBER (155820)	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 04/09/2025
	PROVIDER OR SUPPLIER N CARE LINCOLN	1236 LI	ADDRESS, CITY, STATE, ZIP COD NCOLN AVE VILLE, IN 47714	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	Remove recliner from resident room and replace it with a stationary chair, dated 8/26/22 Re-educate nursing staff to assist resident with toileting needs prior to lunch, dated 9/29/22 If resident is ambulating outside of her room, ensure resident is wearing appropriate footwears. She prefers to be barefoot however, assist her with footwear prior to leaving her room, dated 12/4/22 Staff to assist resident with toileting prior to her bedtime, dated 3/15/23 Re-educate nursing staff to encourage and assist resident to put on proper footwears and keep it on at all times, dated 3/30/23 Therapy to assess walker for safety, dated 4/14/23 Staff to ensure walker is within reach at all times, dated 6/12/23 Ensure slippers are within reach at all times, dated 6/20/23 Staff to check in with resident approximately 30 minutes prior to dinner to see if she needs anything before her tray arrives, dated 9/15/23 Urinalysis for recent falls and increased confusion, dated 10/14/23 Ensure staff bathes resident in shower room for safety of resident and staff in case of an episode where staff has more room to ensure resident's safety, dated 3/2/24 Staff to offer resident assistance with toileting when picking up room tray at lunch, dated 3/4/24 Resident referred to therapy for screen due to lower extremity weakness, dated 3/20/24 Kitchen chair removed from resident room, 3/26/24 Toilet rise to be placed on toilet, dated 4/29/24 Psych med review per (name of mental health provider) Nurse Practitioner (NP), dated 6/28/24 Bolsters placed on bed, dated 7/3/24 Staff to encourage/assist resident with laying in bed with feet elevated rather than sit on the side leaning over the bed, dated 7/14/24			

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

PRINTED: 05/06/2025 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA				(X3) DATE			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	00	COMPLETED	
		155820	B. WI	NG		04/09/	2025
NAME OF F	PROVIDER OR SUPPLIEF	3			ADDRESS, CITY, STATE, ZIP COD		
					NCOLN AVE		
APERIO	N CARE LINCOLN			EVANS	VILLE, IN 47714		
(X4) ID		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 APPROPRIATE DEFICIENCY)		COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	+	TAG	DEFICIENCY		DATE
	throughout the day,	tunities for 1:1 activities					
		n on past falls and attempt to					
	determine cause of falls. Record possible root						
	causes. Educate resident/family/caregivers/IDT as						
	to causes, dated 8/1						
		trips from floor as these appear					
	to be more of a hazard to her as she is always						
	leaned over picking	g at them and pulling them up,					
	putting her at an inc	creased risk for falls, dated					
	8/28/24						
		staff on offering assistance to					
	resident with toileting and her safety checks,						
	dated 8/29/24						
		evaluate resident for safe self					
	transfers, dated 11/2						
	with proper function	istive device to help assist					
		m check for furniture placement					
		nt's needs, dated 12/4/24					
		ppropriate wheelchair, dated					
		ex (ABI) (a test that measures					
		our arms and ankles to check					
		y disease) ordered to assess					
		scular insufficiency to confirm					
		sening disease processes that					
	1	using increase in pain to BLE,					
	dated 1/14/25	-					
	Maintenance to asse	ess status of TV and address					
	issues if found, date	ed 1/21/25					
	Notify MDS for Mo 1/23/25	ed Review for sleep aid, dated					
		ensure resident is wearing					
	appropriate footwea						
		be placed on bed, dated 3/3/25					
		,					
	The clinical record	indicated Resident S fell 34					
	times in the past ye	ar.					
	1						

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AND PLAN OF CORRECTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155820		A. BUI	A. BUILDING 00 COMI B. WING 04/09			ETED 2025	
	PROVIDER OR SUPPLIER	8		1236 LIN	DDRESS, CITY, STATE, ZIP COD NCOLN AVE VILLE, IN 47714		
(X4) ID		STATEMENT OF DEFICIENCIE		ID ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	P	PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		ΤΕ	COMPLETION DATE
	unwitnessed fall wh The resident was fo toilet and the sink v The Interdisciplinar fall on 4/30/24. "To was added to the ca	ent, dated 4/29/24, indicated					
	A 72-hour charting A.M., indicated Res The note did not ind fall took place. The clinical record regarding the fall the The clinical record indicate the physici notified of that fall.						
	The clinical record lacked an IDT note about that fall. The care plan was not updated with a new intervention. A fall risk assessment was not completed.						
	witnessed fall while up off the bed. The clinical record fall. The care plan was rintervention.	a.M., Resident S had a e attempting to pick something lacked an IDT note about that not updated with a new ent, dated 6/6/24, indicated igh risk for falls.					
	Fall 4 On 6/8/24 at 1:45 P	.M., Resident S had an					

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155820	ì í	JILDING	onstruction 00	(X3) DATE COMPL 04/09 /	ETED
	PROVIDER OR SUPPLIEF			1236 LII	ADDRESS, CITY, STATE, ZIP COD NCOLN AVE VILLE, IN 47714		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PROVIDER'S PLAN OF CORRI PREFIX (EACH CORRECTIVE ACTION SHE CROSS-REFERENCED TO THE AP DEFICIENCY)		TE	(X5) COMPLETION DATE
	unwitnessed fall wh The resident was fo The clinical record fall. The care plan was r intervention.	und on the floor. lacked an IDT note about that ot updated with a new ent, dated 6/8/24, indicated					
	unwitnessed fall when She was found sitting to her bed with her The clinical record fall. The care plan was reintervention.	lacked an IDT note about that not updated with a new ent, dated 6/11/24, indicated					
	unwitnessed fall when She was found on the bed. The clinical record fall. "Psych med review provider] NP" was a 6/28/24.	P.M., Resident S had an ille attempting to self toilet. The floor near the foot of the lacked an IDT note about that the per [name of mental health hadded to the care plan on the sent, dated 6/28/24, indicated high risk for falls.					
	unwitnessed fall wh non skid strips from found sitting on the	M., Resident S had an ile attempting to peel up the the floor. The resident was floor by her bed.					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155820		r í	JILDING	nstruction <u>00</u>	(X3) DATE COMPL 04/09/	ETED		
	ROVIDER OR SUPPLIER	2	STREET ADDRESS, CITY, STATE, ZIP COD 1236 LINCOLN AVE EVANSVILLE, IN 47714					
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL		ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO		ιΤΕ	(X5) COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	to the care plan on	ent, dated 7/2/24, indicated						
	Fall 8 On 7/3/24 at 2:00 A unwitnessed fall. The was found sitting of the IDT reviewed to placed on bed" was A fall risk assessment A mental health profindicated mental her reviewed and no mere fall 9 On 7/14/24 at 7:15 witnessed fall while She slid out of bed. The clinical record fall. "Staff to encourage bed with feet elevated."	a.M., Resident S had an the resident slid out of bed and in the floor by her bed. That fall on 7/3/24. "Bolsters added to the care plan. Bent was not completed. Devider note, dated 7/9/24, alth medications were redication changes were made. P.M., Resident S had a reattempting to sit up straight. Lacked an IDT note about that wassist resident with laying in the red rather than sit on the side						
	on 7/14/24.	d" was added to the care plan ent was not completed.						
	unwitnessed fall when She was found sitting to her bathroom. The clinical record fall. The care plan was reintervention.	P.M., Resident S had an nile attempting to self toilet. In on the floor at the entrance lacked an IDT note about that not updated with a new ent was not completed.						

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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 COMPLETED 00 B. WING 04/09/2025 155820 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1236 LINCOLN AVE APERION CARE LINCOLN **EVANSVILLE, IN 47714** (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE Fall 11 On 7/22/24 at 2:25 P.M., Resident S had an unwitnessed fall while attempting to self toilet. She was found sitting on the floor in her room. The clinical record lacked documentation to indicate the physician was notified of that fall. The clinical record lacked an IDT note about that "Staff to offer opportunities for 1:1 activities throughout the day" was added to the care plan on 7/22/24. A fall risk assessment, dated 7/22/24, indicated Resident S was at high risk for falls. Fall 12 On 7/23/24 at 8:15 A.M., Resident S had an unwitnessed fall while attempting to self toilet. She was found sitting on her bedroom floor with her walker in front of her. The clinical record lacked an IDT note about that The care plan was not updated with a new intervention. A fall risk assessment, dated 7/23/24, indicated Resident S was at high risk for falls. Fall 13 On 8/4/24 at 6:20 P.M., Resident S had an unwitnessed fall while in her room. The resident was found sitting on the floor in the doorway to her room. The IDT reviewed that fall on 9/11/24. The care plan was not updated with a new intervention. A fall risk assessment, dated 8/4/24, indicated Resident S was at high risk for falls. Fall 14 On 8/5/24 at 11:20 A.M., Resident S had an

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155820		A. BUILDING B. WING	00	COMP. 04/09		
	PROVIDER OR SUPPLIER		1236 LI	ADDRESS, CITY, STATE, ZIP COD NCOLN AVE SVILLE, IN 47714		
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROP DEFICIENCY)	E	(X5) COMPLETION
TAG	unwitnessed fall who The resident was for doorway to her room The IDT reviewed to information on past cause of falls. Reconsiderate a resident/far causes" was added to the clinical record indicate a review work causes for the residerant and education about A fall risk assessment Resident S was at home Fall 15 On 8/28/24 at 12:30 unwitnessed fall who CNA responded to the found her sitting on to her. The clinical record fall. "Remove non-skid sappear to be more of always leaned over them up, putting her was added to the candard A fall risk assessment Resident S was at home sadded to the candard fall on 8/29/24 at 1:20 for more sadded to the candard fall for the resident was for with her wheelchair tear on her right for The IDT reviewed to "Re-educate nursing the candard for the resident was for the resident was for the IDT reviewed to "Re-educate nursing the candard for the IDT reviewed to "Re-educate nursing the candard for the IDT reviewed to "Re-educate nursing the candard for the IDT reviewed to "Re-educate nursing the candard for the IDT reviewed to "Re-educate nursing the candard for the IDT reviewed to "Re-educate nursing the candard for the IDT reviewed to "Re-educate nursing the candard for the IDT reviewed to "Re-educate nursing the candard for the IDT reviewed to "Re-educate nursing the candard for the IDT reviewed to "Re-educate nursing the candard for the IDT reviewed to "Re-educate nursing the candard for the IDT reviewed to "Re-educate nursing the candard for the IDT reviewed to "Re-educate nursing the candard for the IDT reviewed to "Re-educate nursing the candard for the IDT reviewed to "Re-educate nursing the candard for the IDT reviewed to "Re-educate nursing the candard for the IDT reviewed to "Re-educate nursing the candard for the IDT reviewed to "Re-educate nursing the candard for the IDT reviewed to "Re-educate nursing the candard for the IDT reviewed to "Re-educate nursing the IDT reviewed to "Re-educate nursing the IDT reviewed to "Re-educate nursing the IDT reviewed to "Re-educate nu	hat fall on 9/11/24. "Review falls and attempt to determine rd possible root causes. mily/caregivers/IDT as to to the care plan on 8/12/24. lacked documentation to as completed, possible root ent's falls were determined, at those causes were provided. Int, dated 8/5/24, indicated high risk for falls. D.P.M., Resident S had an attempting to self toilet. A the resident's call light and the floor with her walker next lacked an IDT note about that strips from floor as these of a hazard to her as she is picking at them and pulling at at an increased risk for falls" are plan on 8/28/24, indicated high risk for falls. D.M., Resident S had an attempting to self toilet. Int, dated 8/28/24, indicated high risk for falls. D.M., Resident S had an attempting to self toilet. She had a skin earm.	TAG	DEFICIENCY		DATE

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155820		(X2) MULT A. BUILD B. WING		NSTRUCTION 00	(X3) DATE S COMPL 04/09/	ETED	
	ROVIDER OR SUPPLIER		1	236 LIN	DDRESS, CITY, STATE, ZIP COD NCOLN AVE /ILLE, IN 47714		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		D EFIX AG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	was added to the ca A fall risk assessme Resident S was at h	ent, dated 8/29/24, indicated					
	unwitnessed fall wh found lying on the f The clinical record fall. The care plan was n intervention.	10 P.M., Resident S had an uile in the dayroom. She was aloor in front of her wheelchair. lacked an IDT note about that not updated with a new ant was not completed.					
	unwitnessed fall when The resident was for entrance to her room one side. The clinical record fall. The care plan was mintervention.	0 A.M., Resident S had an aile walking with her walker. und sitting on the floor at the n. The walker was broken on lacked an IDT note about that not updated with a new ent, dated 10/18/24, indicated igh risk for falls.					
	unwitnessed fall who was found sitting or of her wheelchair. The clinical record fall. The care plan was mintervention.	S A.M., Resident S had an ille in her room. The resident in the floor in her room in front lacked an IDT note about that not updated with a new ent, dated 10/27/24, indicated igh risk for falls.					
	1 411 20						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED
		155820	B. WING		04/09/2025
			CTREET	ADDRESS CITY STATE ZID COD	
NAME OF P	ROVIDER OR SUPPLIER	1		ADDRESS, CITY, STATE, ZIP COD	
ADEDION	LOADELINGOLN			INCOLN AVE	
APERIO	N CARE LINCOLN		EVANS	SVILLE, IN 47714	
(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	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	On 11/27/24 at 6:00	P.M., Resident S had a			
	witnessed fall while	e attempting to self toilet.			
	The IDT reviewed that fall on 12/3/24. "Therapy to				
		dent for safe self transfers"			
	was added to the ca	re plan.			
		ent, dated 11/27/24, indicated			
	Resident S was at h				
		-			
	An Occupational Tl	herapy evaluation and plan of			
	_	/3/24, indicated Resident S was			
	certified to receive	therapy two to three times a			
	week from 12/3/24				
	Fall 21				
	On 12/4/24 at 8:45	A.M., Resident S had an			
	unwitnessed fall wh	nile getting up from her chair.			
		ng on her bedroom floor next			
	to her chair.				
	The IDT reviewed t	that fall on 1/8/25. "Therapy to			
	trial assistive device	e to help assist with proper			
		Environmental room check for			
		to better suit resident's			
	needs" were added	to the care plan.			
	A fall risk assessme	ent was not completed.			
		-			
	Fall 22				
	On 12/8/24 at 1:17	A.M., Resident S had an			
	unwitnessed fall in	her room. The resident was			
	found on the floor a	idjacent to her bed.			
	The clinical record	lacked documentation to			
	indicate the physici	an and responsible party were			
	notified of that fall.				
	The clinical record	lacked an IDT note about that			
	fall.				
	The care plan was n	not updated with a new			
	intervention.				
	A fall risk assessme	ent was not completed.			
		-			
	Fall 23				
	On 12/8/24 at 7:00	A.M., Resident S had an			
1	i		1		1

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PRINTED: 05/06/2025 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155820	l í	JILDING	onstruction 00	(X3) DATE COMPL 04/09 /	ETED
	PROVIDER OR SUPPLIEF			1236 LI	ADDRESS, CITY, STATE, ZIP COD NCOLN AVE VILLE, IN 47714	•	
(X4) ID PREFIX		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 APPROPRIA	TE	(X5) COMPLETION
TAG		LISC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		nile walking with her walker. er back on the floor in her					
	room.	er back on the moor in her					
		lacked documentation to an and responsible party were					
	of that fall. The c	linical record lacked an IDT					
	note about that fa	all.The care plan was not					
	updated with a n	ew intervention.A fall risk					
	assessment was i	not completed.Fall 24On					
	12/10/24 at 9:45	A.M., Resident S had an					
	unwitnessed fall while attempting to self						
	toilet. The resident was found sitting on her						
	bathroom floor n	ext to the toilet.The IDT					
	reviewed that fal	l on 1/8/25. The new					
	intervention dete	ermined at that meeting was					
	to increase the fr	equency of monitoring when					
	the resident has l	had a change in					
	condition.The ca	re plan was not updated					
	with a new inter-	vention.A fall risk					
	assessment was i	not completed.Fall 25On					
	12/13/24 at 10:4	9 P.M., Resident S had a					
	witnessed fall. S	taff witnessed the resident					
	sliding out of he	r wheelchair onto the					
	floor.The clinica	l record lacked an IDT note					
	about that fall.Tl	ne care plan was not					
	updated with a n	ew intervention.A fall risk					
	assessment was i	not completed.Fall 26An					
	alert note, dated	12/30/24 at 11:01 P.M.,					
		nt S had no pain or					
		I from her recent fall.A					
		note, dated 12/31/24 at					
		cated Resident S was					
	ĺ						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155820		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 04/09/2025	
	PROVIDER OR SUPPLIER			1236 LII	ADDRESS, CITY, STATE, ZIP COD NCOLN AVE VILLE, IN 47714		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΤE	(X5) COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		II. The note did not indicate					
		how the fall took place. The					
		cked documentation					
		l that took place on					
		nical record lacked					
		o indicate the physician and					
		were notified of that					
		record lacked an IDT note					
	about that fall. The care plan was not						
	updated with a new intervention. A fall risk						
	assessment was not completed.Fall 27On						
	1/7/25 at 9:00 A.M., Resident S had an						
		while attempting to self					
		ent was found sitting on the					
		vay next to a chair that was					
	placed in the hal						
		T reviewed that fall on					
	-	by to fit for appropriate w/c					
		as added to the care plan.A					
		ent, dated 1/13/25,					
		esident S was at high risk for					
		llert note, dated 1/14/25 at					
	· ·	cated Resident S had no					
	•	ort noted from her recent					
		Note, dated 1/28/25 at					
	· ·	cated that the committee					
		e fall from 1/14/25. The					
		om emergency light					
		resident was found on the					
		room. "Therapy to fit for					
	appropriate whee	elchair" was added to the					
	care plan on 1/13	3/25."Ankle Brachial Index					

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	OF CORRECTION	IDENTIFICATION NUMBER 155820	î í	ILDING	00	COMPL 04/09/	ETED
	PROVIDER OR SUPPLIER			1236 LIN	DDRESS, CITY, STATE, ZIP COD NCOLN AVE VILLE, IN 47714		
(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)	ΓE	(X5) COMPLETION DATE
		measures blood pressure ankles to check for					
		disease) ordered to assess vascular insufficiency to					
	processes that ma	ut any worsening disease ay possibly be causing					
	_	o bilateral lower extremities ed to the care plan on					
		k assessment, dated d that Resident S was at					
	~	s.Fall 29On 1/19/25 at 3:01 s had an unwitnessed fall					
		n. The resident was found or in front of her stationary					
		l record lacked an IDT note ne care plan was not					
	•	ew intervention.A fall risk not completed.Fall 30On					
		A.M., Resident S had an in her room. She was found					
		an sitting on the ground with o her.The clinical record					
		ation to indicate the sponsible party were					
		all.The clinical record lacked at that fall.The care plan					
	fall risk assessme	with a new intervention.A ent was not completed.Fall					
	had an unwitness	10:24 A.M., Resident S sed fall while attempting to					
		NA responded to a call light com and found the resident					

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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	
		155820	B. WING			04/09/2025	
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
					NCOLN AVE		
APERIO	N CARE LINCOLN			VANS'	VILLE, IN 47714		
(X4) ID		STATEMENT OF DEFICIENCIE		D	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION		EFIX AG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
IAG		coom floor in front of her	1.	AU			DATE
		t reported hitting her head					
		have a hematoma on the					
		head. The IDT reviewed that					
	•	Maintenance to assess					
		address issues if found"					
		care plan.A fall risk					
		not completed.Fall 32On					
		A.M., Resident S had an					
		while in her room. The					
		nd sitting on the floor in the					
	-	of her wheelchair. The IDT					
		l on 1/24/25. "Notify MDS					
		for sleep aid" was added to					
	_	all risk assessment, dated					
	1/23/25, indicate	d that Resident S was at					
	high risk for falls	s.Fall 33On 1/25/25 at 12:20					
	P.M., Resident S	had an unwitnessed fall					
	while in her room	n. A CNA responded to a					
	call light in the r	esident's room and found the					
	resident sitting o	n the floor next to her					
	wheelchair. The	resident was noted to have					
	a hematoma to th	ne left side of her					
	forehead.The ID	T reviewed that fall on					
	1/28/25. "Staff to	frequently ensure resident					
	is wearing appro	priate footwear" was added					
		A fall risk assessment was					
	not completed.A	mental health provider					
	_	25, indicated Resident S					
	ŕ	disturbance. A medication					
		ep was not ordered at that					
		sults, dated 1/28/25, were					
		.51.5, 44.64 1/20/25, 11010					

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	OF CORRECTION	IDENTIFICATION NUMBER 155820	A. BU	A. BUILDING <u>00</u> B. WING		COMPLETED 04/09/2025	
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
APERION	N CARE LINCOLN				NCOLN AVE VILLE, IN 47714		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	*	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION DATE
	negative. Fall 34	On 3/3/25 at 12:12 A.M.,					
	Resident S had a	n unwitnessed fall while in					
	bed. The resident	t indicated she slid out of					
	bed. She was fou	and sitting on the floor					
	beside the left sid	de of her bed.The IDT					
	reviewed that fal	l on 3/3/25. "Bolster					
	mattress to be pla	aced on bed" was added to					
	the care plan.A fa	all risk assessment, dated					
	3/3/25, indicated	that Resident S was at high					
	risk for falls.On	4/4/25 at 1:18 P.M.,					
	Resident S was o	bserved sitting in her					
	wheelchair in her	r room eating lunch. The					
	resident was wea	ring socks without nonskid					
	bottoms. A kitch	en chair was observed in					
	the room. The ca	ll light was wrapped around					
	the kitchen chair	and was not within reach of					
	the resident. The	re was not a bolster					
	mattress on the b	ed. There were no bolsters					
	in the room. The	re was not a "Call, Don't					
	Fall" sign in the	resident's room. There was					
	not a "Call for as	sistance with showers" sign					
	in the bathroom.	There was not a STOP sign					
	in the shower ent	try. There was not a toilet					
	riser on the toilet	In an interview on 4/8/25					
	· ·	Director of Nursing					
		that after a resident fell, the					
		sponsible party were					
		Γ met the next business day					
		and determine a new and					
		vention. The intervention					
	-	care plan immediately.					
	There should be	a new intervention with					

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155820	ì í	JILDING	nstruction <u>00</u>	(X3) DATE COMPL 04/09/	ETED
NAME OF PROVIDER OR SUPPLIER APERION CARE LINCOLN			1236 LII	DDRESS, CITY, STATE, ZIP COD NCOLN AVE VILLE, IN 47714			
(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 APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
PREFIX	every fall. If the other form of ass be reviewed and appropriately and intervention wou necessary. On 4/9 DON provided a Program policy, indicated "The p measures which needs of each resof falls and implicate interventions to p supervision The includes the follonotification of pl representative Concept Identification of each fall, interventially interventions to program policy, indicated "The program peasures which needs of each resoft falls and implication of pl representative Continues the follonotification of each fall, intervent each fall, as appropriately appropriately and intervent in the program policy in the pro	intervention was a lab or sessment, the results would followed up on d timely, and another ald be determined if 0/25 at 12:14 P.M., the current Fall Prevention revised 11/21/17, that rogram will include determine the individual sident by assessing the risk ementation of appropriate provide necessary me Fall Prevention Program owing components: nysician, family/legal		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
	possible safety in	ovided and determine nterventions Fall/safety y include but are not limited					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

V9TI11

Facility ID: 000443

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

PRINTED: 05/06/2025 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155820		, ,	LDING	NSTRUCTION 00	(X3) DATE : COMPL 04/09/	ETED	
NAME OF PROVIDER OR SUPPLIER APERION CARE LINCOLN			1236 LI	DDRESS, CITY, STATE, ZIP COD NCOLN AVE VILLE, IN 47714			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	I	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 0692 SS=D Bldg. 00	within the reside lights are answer will be monitore proper fitting sho non-skid".On 2 DON provided a Documentation I policy that indica professional shall their own prompthat are complete Entries will be change in the reswill include internotifications made entries must be dwritten, and will that the original made".This citat IN00449780 and (2) 483.25(g)(1)-(3)	all device will be placed int's reach at all times Call red promptly Foot wear d to ensure the resident has been and/or footwear is 1/9/25 at 12:14 P.M., the current undated Procedures and Guidelines ated "Each health care I be responsible for making t, factual, concise, entries e, appropriate, and readable e made whenever there is a ident's condition. The entry eventions and appropriate de in a timely manner Late lated on the date it is include the date and time entry should have been ion related to Complaints IN00450874.3.1-45(a)					
Didg. 00	review, the facility care and services in significant weight le physician of signification be reviewed by the	on, interview, and record failed to provide nutritional cluding failure to identify oss, failure to notify the cant weight loss, and failure to Registered Dietician for 1 of 1 for weight loss (Resident S).	F 069	92	What corrective actions have been accomplished for those residents found to have been affected by the deficient practice. Resident S's weight has been reviewed by the Registered Dietician. Resident S's weight loss has been reviewed by the Registered Dietician.	1	05/06/2025

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Event ID:

V9TI11

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SU			SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	A. BUILDING <u>00</u>			COMPLETED	
		155820	B. WING 04/09/2025				2025	
				CTREET	ADDRESS CITY STATE ZIR COD	<u> </u>		
NAME OF F	PROVIDER OR SUPPLIER	t			ADDRESS, CITY, STATE, ZIP COD			
ADEDIO	U CARE LINGOLNI				INCOLN AVE			
APERIOI	N CARE LINCOLN			EVANS	SVILLE, IN 47714			
(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 OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	On 4/4/25 at 12:40	P.M., Resident S's clinical			communicated to the Physicia	ın.		
	record was reviewe	d. Diagnoses included, but			ĺ			
	were not limited to,	dementia, diabetes mellitus,			How the facility will identify			
	and dysphagia.				other residents having the			
					potential to be affected by th	ie		
	The most current A	nnual Minimum Data Set			same deficient practice:			
	(MDS) Assessment	, dated 2/5/25, indicated			_			
	Resident S had seve	ere cognitive impairment,			All residents have the potentia	al to		
	required setup assis	tance from staff for eating,			be affected by the alleged def			
	weighed 179 pound	s (lbs), and had no weight			practice.			
	loss.							
					A New Weight Process has be	een		
	The most current Q	uarterly MDS Assessment,			implemented.			
	dated 2/20/25, indic	eated Resident S had severe						
	cognitive impairme	nt, required setup assistance			The Dietary Manager has bee			
	from staff for eating	g, weighed 132 lbs, and had no		educated on the new Weight				
	weight loss.				Process including notification	to		
					the RD with documentation.			
		e plan conference was						
	completed on 11/14	24. The care plan was			The DON has been educated	on		
	reviewed and updat	ed.			the New Weight Process inclu	iding		
					notification to the Physician w	ith		
		ll status care plan, revised on			documentation.			
		Resident S was at risk for						
	altered nutritional s	tatus.						
					Measures the facility will tak			
		rders included, but were not		to ensure that the prol				
	limited to:				be corrected and will not rec	ur:		
		ron) oral tablet 15 milligrams						
	, -,	let by mouth at bedtime related			A New Weight Process has be	een		
	to major depressive	disorder, dated 1/30/2025			implemented.			
		ng - Give one tablet by mouth			The Dietary Manager has bee	n		
	one time a day relat	ted to dementia, dated 1/30/25			educated on the new Weight			
					Process including notification	to		
		ights and vitals tab indicated			the RD with documentation.			
		ghed on the following days:						
	4/5/24 - 192.2 lbs st	_			The DON has been educated			
	5/8/24 - 186.6 lbs st	_			the New Weight Process inclu	-		
6/7/24 - 183.4 lbs standing				notification to the Physician w	ith			

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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 <u>00</u>			COMPLETED	
		155820				04/09/	2025
NAME OF P	ROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP COD		
					NCOLN AVE		
APERION	N CARE LINCOLN			EVANS	VILLE, IN 47714		
(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 OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	10	DATE
	7/10/24 - 182.1 lbs	standing			documentation.		
	8/9/24 - 183.6 lbs st	tanding					
	9/9/24 - 181.2 lbs st	tanding			Quality assurance plans to		
	10/10/24 - 178.8 lbs	s wheelchair			monitor facility performance	to	
	12/16/24 - 179.0 lbs	s wheelchair			make sure that corrections a	re	
	1/3/25 - 179.3 lbs st	tanding			achieved and are permanent	:	
	2/18/25 - 131.7 lbs	wheelchair (a 26.55% weight			-	ļ	
	loss)				DON/Designee will perform 5	ļ	
					Medical Record Reviews a we	ek	
	0.0	note, dated 1/29/25 at 3:20			to ensure any weight loss has		
	P.M., indicated the	mental health Nurse			been identified, RD notified, a		
	Practitioner (NP) re	viewed the resident's mental			Physician notified.		
	health medications	on 1/28/25. Namzaric (a					
	medication used to	slow the progression of			The results of the above audit	s will	
	dementia with a sid	e effect of anorexia) was		be reviewed in the Quality			
	discontinued due to	not eating and weight loss.		Assurance Meeting monthly until			
	Remeron (an antide	pressant medication with side			100% compliance is achieved	for 3	
	effects of increased	appetite and weight gain) was			consecutive months. The QAA	4	
	decreased from 45 i	mg at bedtime to 15 mg at			Committee will identify any tre	nds	
		(a medication used to slow the			or patterns and make		
		entia without the anorexia side			recommendations to revise the	е	
	effect) 5 mg daily w	vas ordered.			plan of correction as indicated	ı.	
		nter progress note, dated					
		M., included a weight loss					
	_	ted the patient was tolerating					
	-	ation changes. No medication					
	changes were made	at that visit.					
	A nevahiatmy and	ntar progress note dated					
		nter progress note, dated M., indicated that the resident					
		eight loss and to have staff					
	re-weigh the resider						
	ic-weigh the resider						
	A nsychiatry encou	nter progress note, dated					
		M., indicated that the resident				ļ	
		eight loss and to have staff				ļ	
	_	nt. It indicated the mental					
	-	waiting for the March weight.				ļ	
	nearm provider was	waiting for the Maten weight.				ļ	
			1			Į.	

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155820	IFICATION NUMBER A. BUILDING 00			(X3) DATE COMPL 04/09 /	ETED
NAME OF PROVIDER OR SUPPLIER APERION CARE LINCOLN			1236 LII	DDRESS, CITY, STATE, ZIP COD NCOLN AVE VILLE, IN 47714			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY 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
		lacked documentation to twas re-weighed after the taken.					
		lacked documentation to t was referred to the dietitian					
	The clinical record of the resident by the	lacked a nutritional assessment ne dietitian.					
		lacked notification to the resident's significant weight					
	indicate the residen	lacked documentation to t was reviewed by the cam (IDT) for weight loss.					
	sitting in her wheeld of her shirt was han that time, the reside lot of weight, and h	.M., Resident S was observed chair in the hallway. The strap ging over her shoulder. At ent indicated that she had lost a er clothes did not fit anymore. hy she had lost weight.					
	S. The resident weight. wheelchair weight. 39.5 lbs. CNA 18 co weighed 123.3 lbs (.M., CNA 18 weighed Resident ghed 162.8 lbs including the The wheelchair's weight was onfirmed Resident S currently (a 6.38% weight loss since 1/3/25).					
	(DON) indicated the ran monthly reports follow for weight lo Practitioner (NP) al weight loss. At that	.M., the Director of Nursing at the Registered Dietitian (RD) to know which residents to bess. The facility's Nurse so reviewed charts monthly for time, the DON indicated she any notes from the RD or NP					

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	AND PLAN OF CORRECTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155820		(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 04/09/2025
	PROVIDER OR SUPPLIER	₹	1236 LI	ADDRESS, CITY, STATE, ZIP COD NCOLN AVE SVILLE, IN 47714	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPF	TION (X5) LD BE ROPRIATE COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	notes she could find	S's weight loss. The only drelated to Resident S's om the mental health NP.			
	indicated that the re	A.M., the MDS Coordinator esident had a weight loss and it			
	MDS Assessment,	oded as such on the Quarterly but the weight loss did not			
		itian did not reach out to her.			
		P.M., the DON provided a ietitian Consultant job			
	description, dated 7	7/3/17, that indicated "Essential			
	_	sibilities: Assesses the customers inclusive			
		ance Ensures appropriate autritional assessment and			
		vention in the customer chart			
	-	views the documentation of			
	responds appropria	tritional concerns and tely".			
		P.M., the DON provided a			
		licy, revised 10/17/19, that ident shall be weighed on			
		ast monthly thereafter, or in			
		sysician orders or plan of care d be obtained if there is a			
		or greater (loss or gain) since			
	_	weight Undesired or ht gains/loss of 5% in 30 days,			
	7.5% in three mont	hs, or 10% in six months shall			
	be reported to the p Dietary Manager as	hysician, Dietician and/or			
	This citation relates	s to Complaint IN00449780.			
	3.1-46(a)(1)				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155820		(X2) MULTIPLE C A. BUILDING B. WING	construction 00	(X3) DATE SURVEY COMPLETED 04/09/2025
ROVIDER OR SUPPLIER		1236 L	INCOLN AVE	
SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (BACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	
483.25(g)(4)(5) Tube Feeding Mgi	mt/Restore Eating Skills			
review, the facility orders were followed feedings were admir reviewed for tube for nutrition refusals we feeding equipment of (Resident G) Finding includes: On 4/3/25 at 11:44 A sitting in her wheeld feeding) formula, do the room but was not A syringe was observed sated 4/1/25. On 4/4/25 at 1:24 P. observed turned off Resident G was not syringe was observed dated 4/1/24. On 4/7/25 at 11:37 A observed turned off Resident G was not feeding tube was we there was no cap on On 4/8/25 at 10:57 A observed turned off Resident G was not feeding tube was we there was no cap on On 4/8/25 at 10:57 A observed turned off Resident G was not On 4/8/25 at 2:43 P.	failed to ensure physician d and a resident's nutritional nistered for 1 of 1 residents redings. A resident's enteral ere not documented, and was not changed daily. A.M., Resident G was observed thair in her room. Jevity (tube red 4/2/25, was observed in of thooked up to the resident. red hanging in a bag and M., the enteral nutrition was in Resident G's room. in her room at that time. A red hanging in a bag and was A.M., the enteral nutrition was in Resident G's room. in her room at that time. The rapped around the pole and the end of the tubing. A.M., the enteral nutrition was in Resident G's room. in her room at that time. The rapped around the pole and the end of the tubing. A.M., the enteral nutrition was in Resident G's room. in her room at that time. M., the enteral nutrition was in Resident G's room. in her room at that time.	F 0693	What corrective actions have been accomplished for those residents found to have been affected by the deficient practice. Resident G is receiving her E Feeding as Physician order undersused. Resident G's refusals are beind documented. Resident G's Enteral Feeding equipment is being changed. How the facility will identify other residents having the potential to be affected by the same deficient practice: All residents with Enteral Feed have the potential to be affected by the alleged deficient practicular Licensed Nursing Staff have been educated on following Physician orders. QMA's have been educated of following Physician orders. Licensed Nursing Staff have been educated on documentation of resident refusal of Enteral Feeding.	nteral nless ng ding ted ce. been ian
observed turned off in Resident G's room. Resident G was not in her room at that time.			QMA's have been educated of	on
	ROVIDER OR SUPPLIER SUMMARY S (EACH DEFICIENCY REGULATORY OR 483.25(g)(4)(5) Tube Feeding Mgr Based on observation review, the facility of orders were follower feedings were admit reviewed for tube feeding equipment of (Resident G) Finding includes: On 4/3/25 at 11:44 A sitting in her wheeled feeding) formula, dathe room but was not A syringe was observed was dated 4/1/25. On 4/4/25 at 1:24 P. observed turned off Resident G was not syringe was observed dated 4/1/24. On 4/7/25 at 11:37 A observed turned off Resident G was not feeding tube was writhere was no cap on On 4/8/25 at 10:57 A observed turned off Resident G was not feeding tube was writhere was no cap on On 4/8/25 at 2:43 P. observed turned off Resident G was not On 4/8/25 at 2:43 P. observed turned off Resident G was not On 4/8/25 at 2:43 P. observed turned off Resident G was not On 4/8/25 at 2:43 P. observed turned off Resident G was not On 4/8/25 at 2:43 P. observed turned off Resident G was not On 4/8/25 at 2:43 P. observed turned off Resident G was not On 4/8/25 at 2:43 P. observed turned off Resident G was not On 4/8/25 at 2:43 P. observed turned off Resident G was not On 4/8/25 at 2:43 P. observed turned off Resident G was not On 4/8/25 at 2:43 P. observed turned off Resident G was not On 4/8/25 at 2:43 P. observed turned off Resident G was not On 4/8/25 at 2:43 P. observed turned off Resident G was not On 4/8/25 at 2:43 P. observed turned off Resident G was not On 4/8/25 at 2:43 P. observed turned off Resident G was not On 4/8/25 at 2:43 P. observed turned off Resident G was not On 4/8/25 at 2:43 P. observed turned off Resident G was not On 4/8/25 at 2:43 P. observed turned off Resident G was not On 4/8/25 at 2:43 P. observed turned off Resident G was not On 4/8/25 at 2:43 P. observed turned off Resident G was not On 4/8/25 at 2:43 P. observed turned Off Resident G was not On 4/8/25 at 2:43 P. observed turned Off Resident G was not On 4/8/25 at 2:43 P. observed turned Off Resident G was not On 4/8/25 at 2:43 P. observed turned Off Reside	ROVIDER OR SUPPLIER N CARE LINCOLN SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION 483.25(g)(4)(5) Tube Feeding Mgmt/Restore Eating Skills Based on observation, interview, and record review, the facility failed to ensure physician orders were followed and a resident's nutritional feedings were administered for 1 of 1 residents reviewed for tube feedings. A resident's enteral nutrition refusals were not documented, and feeding equipment was not changed daily. (Resident G) Finding includes: On 4/3/25 at 11:44 A.M., Resident G was observed sitting in her wheelchair in her room. Jevity (tube feeding) formula, dated 4/2/25, was observed in the room but was not hooked up to the resident. A syringe was observed hanging in a bag and was dated 4/1/25. On 4/4/25 at 1:24 P.M., the enteral nutrition was observed turned off in Resident G's room. Resident G was not in her room at that time. A syringe was observed hanging in a bag and was dated 4/1/24. On 4/7/25 at 11:37 A.M., the enteral nutrition was observed turned off in Resident G's room. Resident G was not in her room at that time. The feeding tube was wrapped around the pole and there was no cap on the end of the tubing. On 4/8/25 at 10:57 A.M., the enteral nutrition was observed turned off in Resident G's room. Resident G was not in her room at that time. On 4/8/25 at 2:43 P.M., the enteral nutrition was observed turned off in Resident G's room. Resident G was not in her room at that time.	ROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION 483.25(g)(4)(5) Tube Feeding Mgmt/Restore Eating Skills Based on observation, interview, and record review, the facility failed to ensure physician orders were followed and a resident's nutritional feedings were administered for 1 of 1 residents reviewed for tube feedings. A resident's enteral nutrition refusals were not documented, and feeding equipment was not changed daily. (Resident G) Finding includes: On 4/3/25 at 11:44 A.M., Resident G was observed sitting in her wheelchair in her room. Jevity (tube feeding) formula, dated 4/2/25, was observed in the room but was not hooked up to the resident. A syringe was observed hanging in a bag and was dated 4/1/25. 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ROVIDER OR SUPPLIER ROVIDER OR SUPPLIER ROVARE LINCOLN SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR IS: UPENTIFYING INFORMATION 483.25(g)(4)(5) Tube Feeding Mgmt/Restore Eating Skills Based on observation, interview, and record review, the facility failed to ensure physician orders were followed and a resident's nutritional feedings were administered for 1 of 1 residents reviewed for tube feedings. A resident's enteral nutrition refusals were not documented, and feeding equipment was not changed daily. (Resident G) Finding includes: On 4/3/25 at 11:44 A.M., Resident G was observed sitting in her wheelchair in her room Jevity (tube feeding) formula, dated 4/2/25, was observed hanging in a bag and was dated 4/1/25. On 4/4/25 at 1:24 P.M., the enteral nutrition was observed turned off in Resident G's room. Resident G was not in her room at that time. A syringe was observed hanging in a bag and was dated 4/1/24. 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Event ID:

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If continuation sheet

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05/06/2025 PRINTED: FORM APPROVED OMB NO. 0938-039

CENTERS FOR MEDICARE & MEDICAID SERVICES 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 04/09/2025 155820 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1236 LINCOLN AVE APERION CARE LINCOLN **EVANSVILLE, IN 47714** (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 documentation of resident refusal On 4/7/25 at 11:16 A.M., Resident G's clinical of Enteral Feeding. record was reviewed. Diagnoses included, but were not limited to, pneumonitis due to inhalation of food and vomit, dysphagia, and dementia. Measures the facility will take to ensure that the problem will The most current Significant Change Minimum be corrected and will not recur: Data Set (MDS) Assessment, dated 3/17/25, Licensed Nursing Staff have been indicated Resident G had mild cognitive impairment, was dependent on staff (staff does all educated on following Physician of the effort) for transfers, and the resident orders. received 51% or more of her nutrition through a feeding tube. QMA's have been educated on following Physician orders. The most recent care conference was completed on 2/27/25. The care plans were reviewed and Licensed Nursing Staff have been educated on documentation of updated. resident refusal of Enteral A current tube feeding care plan, initiated 3/17/25, Feeding. included an intervention to monitor caloric intake. QMA's have been educated on Current physician orders included, but were not documentation of resident refusal limited to: of Enteral Feeding. Nothing By Mouth (NPO) diet - may have four ounces (oz) cups of ice chips at bedside and per Quality assurance plans to her request for dysphagia following cerebral monitor facility performance to infarction, dated 3/14/25 make sure that corrections are achieved and are permanent: Continuous Enteral Feeding: Formula: Jevity 1.5 at 60 milliliters (ml) per hour for 22 hours per day DON/Designee will perform 5 (1320 ml total), off for 2 hours per day Activities of Medical Record Reviews a week Daily Living (ADLs); Flush with 250 ml of water for 4 weeks, then 3 times a week every six hours. Monitor every shift, dated for 8 weeks to ensure Physician 3/25/25. Orders related to Enteral Feeding is being followed. Change Syringe every 24 hours and as needed,

FORM CMS-2567(02-99) Previous Versions Obsolete

dated 3/14/25

The Medication Administration Record (MAR) for

the continuous enteral feeding for March and

Event ID:

V9TI11

Facility ID: 000443

If continuation sheet

DON/Designee will perform 5 Medical Record Reviews a week

for 8 weeks to ensure

for 4 weeks, then 3 times a week

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STATEMI	ENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	LTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLA	N OF CORRECTION	IDENTIFICATION NUMBER	A. BUI	LDING	00	COMPL	LETED
		155820	B. WIN	lG		04/09/	/2025
			<u> </u>	CTDEET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF	PROVIDER OR SUPPLIE	R			NCOLN AVE		
ADEDIO	ON CARE LINCOLN				VILLE, IN 47714		
APERIC	ON CARE LINCOLN			EVAINS	VILLE, IN 47714		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	I	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	April was reviewed	d. The record included, but was			documentation of Enteral Fee	ding	
	not limited to:				is completed as needed.		
	3/14/25 - 180 (ever	ning); 360 (night) - 540 (total)					
		50 (evening); 400 (night) - 500			The results of the above audit	s will	
	(total)				be reviewed in the Quality		
	3/16/25 - 50 (day); 50 (evening); 400 (night) - 500				Assurance Meeting monthly u	ntil	
	(total)				100% compliance is achieved		
	3/17/25 - not documented (day); 360 (evening);				consecutive months. The QAA	4	
	480 (night) - 840 (total)				Committee will identify any tre	nds	
	`	day); 420 (evening); 390 (night)			or patterns and make		
	- unable to be calculated				recommendations to revise the		
	3/19/25 - 370 (day)			plan of correction as indicated			
	(total)						
	3/20/25 - 477 (day); 60 (evening); 400 (night) - 937						
	(total)						
	1); 60 (evening); 390 (night) - 1050					
	(total)						
	` • ′); 1320 (evening); 400 (night) -					
	2085 (total)	1220 (
); 1320 (evening); 46 (night) -					
	1786 (total)	2. 420 (
); 420 (evening); 395 (night) -					
	1165 (total)); 360 (evening); 460 (night) -					
	1150 (total)	, 300 (evening), 400 (night) -					
	` ′	; 1320 (evening); 480 (night) -					
	1800 (total)	, 1320 (evening), 400 (ilight) -					
	\ /	; resident refused (evening);					
	400 (night) - 750 (t						
	\ \ \ \ \); 360 (evening); 480 (night) -					
	1200 (total)	,, (
	` ′); 360 (evening); NA (night) -					
	860 (total)	(··· · · · · · · · · · · · · · · · · ·					
	` ′); 360 (evening); 480 (night) -					
	1280 (total)	6), 5 (6)					
	` ′); "y" (evening); 480 (night) -					
	total unable to be c						
		1122 (evening); NA (night) -					
	1482 (total)	(-·)// - ··· · (···········/					
	` ′	ay); 1.5 (evening); NA (night) -					
		C C C C C C C					1

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER) 155820		l í	JILDING	nstruction <u>00</u>	(X3) DATE : COMPL 04/09/	ETED	
	PROVIDER OR SUPPLIER			1236 LII	NDDRESS, CITY, STATE, ZIP COD NCOLN AVE VILLE, IN 47714		
(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 APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	total unable to be ca 4/3/25 - 60 (day); 4 (total) 4/4/25 - 360 (day); (total) 4/5/25 - 360 (day); (total) 4/6/25 - 240 (day); (total) The clinical record physician when the than the ordered 13 period. The clinical record enteral nutrition waresident refused nutrand 4/8/15 outside of the physician. On 4/8/25 at 1:45 P (DON) indicated the refused her enteral refu						

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Event ID:

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155820		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 04/09/2025	
	PROVIDER OR SUPPLIER	2	1236 L	ADDRESS, CITY, STATE, ZIP COD INCOLN AVE SVILLE, IN 47714	
(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)	(X5) COMPLETION DATE
	tolerance, intake an notations on physic characteristics such etc. are essential to being provided". On 4/9/25 at 12:14 current Physician-F Condition policy, re "The facility will in resident's physician alter treatment". On 4/9/25 at 12:14 current undated Do Guidelines policy the professional shall be own prompt, factual complete, appropriate made whenever resident's condition interventions and a pin a timely manner. On 4/9/25 at 1:30 P	d output records, nursing al assessment for as skin turgor, available labs, ensure adequate fluids are P.M., the DON provided a family Notification- Change in evised 11/13/18, that indicated aformconsult with thewhen there is: a need to P.M., the DON provided a cumentation Procedures and that indicated "Each health care the responsible for making their l, concise, entries that are the, and readable Entries will there is a change in the The entry will include oppropriate notifications made			
F 0760 SS=G Bldg. 00	483.45(f)(2) Residents are Fre	e of Significant Med Errors			
-	failed to ensure resi significant medicat reviewed for hospit	view and interview, the facility dents were free from ion errors for 1 of 2 residents alization. A resident did not ure medications and was	F 0760	How corrective action will be taken for those affected by to alleged deficient practice: Resident B is receiving hypertensive medications as ordered.	03/00/2023

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admitted to the hospital two times for

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.3

How will the facility identify

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	IULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	00	COMPLETED	
		155820	B. W	ING		04/09/2025	
		<u> </u>		STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER	8			INCOLN AVE		
APERION	N CARE LINCOLN				SVILLE, IN 47714		
		OT A MEN AND AN AND PROPERTY AND	1		, I		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	(X5)	NT.
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION	N
TAG		encies. (Resident B)	+	TAG		DATE	
	hypertensive emerg	encies. (Resident B)			other residents having the		
	Finding includes:				potential to be affected by the same deficient practice?	re	
	r manig merades.				All residents that have		
	On 4/7/25 at 9·24 A	.M., Resident B's clinical record			Hypertensive medications ord	ered	
		noses included, but were not			have the potential to be affect		
	limited to, hypertensive encephalopathy.				by alleged deficient practice.		
		anios to, il pottonio il onoophinophino,			education provided		
	The most recent An	nual Minimum Data Set			to licensed nurses on ensuring	,	
		/3/25, indicated Resident B			medications are administered	-	
	was moderately cog			prescribed.			
	,						
	Care plans included, but were not limited to:				The measures the facility will	ı	
	P				take or systems the facility v		
	Resident had a diagnosis of hypertension:				alter to ensure that the probl		
	Administer medicat	tions as ordered; Assess for			will be corrected and will no		
	side effects and effe	ectiveness; Notify physician of			occur:		
	noted signs/sympton	ms for further evaluation,			education provided to		
	initiated 2/17/24.				licensed nurses on ensuring		
					medications are administered	as	
	Physician orders in	cluded, but were not limited to:			prescribed.		
					Quality Assurance plans to		
	· ·	eation used to treat high blood			monitor facility performance		
		t 12.5 mg (milligrams) give one			make sure that corrections a		
	-	times a day for hypertension;			achieved and are permanent		
	Start date 2/9/24				DON/Designee will compl		
					5 observations of Medication		
		rate (a medication used to			Administration a week for 4		
		ssure) ER (extended release)			weeks, then 3 times a week for		
		ve one tablet by mouth two			weeks to ensure hypertensive		
	• •	oxysmal atrial fibrillation; Start			medications are being		
	date 2/9/24				administered as ordered.		
	Liginoppil (c.m.c.li	ation used to treat bigh blood			DON/Decimes will some	oto	
		ation used to treat high blood t 10 mg give one tablet by			DON/Designee will compl		
		day for hypertension; Start			5 Medical Record reviews a w		
	date 2/9/24	day for hypertension; Start			then 3 times a week for to ens	uie	
	uale 2/3/24				hypertensive medication are		
	Clanidina (a madia	ation used to treat high blood			administered.		
	· ·	Tablet 0.1 mg give one tablet			The regulte of the object		
	pressure) nei Orai	radict 0.1 mg give one tablet	1		The results of the above	1	

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	IULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		UILDING	00	COMPL	
		155820	B. W	'ING		04/09/	/2025
NAME OF P	DROWNED OF CURPUSE			STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER				NCOLN AVE		
APERIO	N CARE LINCOLN			EVANS	VILLE, IN 47714		
(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 es a day for hypertension, hold	+	TAG	audits will be reviewed in the		DATE
	1 -	essure is less than 160; Start			Quality Assurance Meeting		
	date 3/26/24 Discor				monthly until 100% complianc	e is	
					achieved for 3 consecutive	0 10	
	The electronic medi	ication administration record			months. The QAA Committee	will	
	(MAR) indicated Resident B did not receive his				identify any trends or patterns	and	
	blood pressure medications (Carvedilol 12.5 mg,				make recommendations to rev	vise	
		rate ER 60 mg, or Lisinopril 10			the plan of correction as		
		n 6/25/24. in accordance with			indicated.		
	the physician orders.						
	A nursing progress note, dated 6/25/24 at 2:06						
	P.M., indicated Resident B was heard yelling from						
	his bedroom, the Cl	NA went to check on him, and					
	found him kneeling	with his elbows on the floor in					
		nd his rollator was next to him.					
		arefoot, this nurse and two					
		to lie down in a comfortable					
	1 ~	then assessed the resident					
	1	was observed at this time.					
		CNAs then tried to assist the but the resident started					
		k and neck pain, the nurse then					
		e the resident and notified					
		communication line). Triage					
		nd the resident to the					
	l -	mbulance was called and came					
		t off the floor and transported					
	him to the hospital.	The blood pressure was					
	155/84.						
	A hospital admission	on history, dated 6/25/24 at					
		ed Resident B's blood pressure					
		nission and resident had a					
		gency with encephalopathy-					
	likely due to not rec	ceiving proper medication					
	regimen in nursing	home."					
	On 10/1/24 a new n	hysician's order for hydralazine					
		to treat high blood pressure)					

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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 COMPLETED 00 B. WING 04/09/2025 155820 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1236 LINCOLN AVE APERION CARE LINCOLN **EVANSVILLE, IN 47714** (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 DEFICIENCY) TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE HCl oral tablet 25 mg give 1 tablet by mouth every eight hours as needed was initiated. The electronic medication administration record (MAR) indicated Resident B did not receive his previous doses of blood pressure medications (Carvedilol 12.5 mg, Isosorbide Mononitrate ER 60 mg, Lisinopril 10 mg) on 12/7/24 at 8:00 P.M., and did not have a blood pressure recorded or blood pressure medications (Hydralazine 50 mg) given on 12/7/24 at 4:00 P.M. A nurses note, on 12/8/24 at 4:04 A.M., indicated Resident B was having chest pain and was given nitroglycerin (medication used to treat chest pain). A nurses note, on 12/8/24 at 6:00 A.M., indicated Resident B had been transported to the hospital. A hospital history and physician note, dated 12/8/24 at 11:30 A.M., indicated Resident B's blood pressure was 224/174 and he was having a hypertensive emergency. During an interview on 4/8/25 at 1:23 P.M., the Director of Nursing (DON) indicated each resident had different blood pressure parameters to notify the physician about, nursing staff should use their nursing judgement if a blood pressure falls outside of normal parameters, and that the charting system flags systolic blood pressure above 139 as elevated. On 4/9/25 at 12:14 P.M., a policy relating to blood pressure parameters and following physician orders was requested and not provided. During an interview on 4/9/25 at 1:20 P.M., the regional nurse indicate the policy of the facility was for staff to follow physician orders.

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	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA			ONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155820	A. BU B. WI	JILDING	00	COMPL 04/09/	
		133620	B. WI			04/09/	2023
NAME OF P	ROVIDER OR SUPPLIER	1			ADDRESS, CITY, STATE, ZIP COD		
APERION	N CARE LINCOLN				WILLE, IN 47714		
(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	REGULATORY OR	R LSC IDENTIFYING INFORMATION	TAG		DEFICIENCE!		DATE
	3.1-48(c)(2)						
F 0804	483.60(d)(1)(2)						
SS=E	Nutritive Value/Appear, Palatable/Prefer						
Bldg. 00	Temp						
	Based on observation, record review, and interview, the facility failed to ensure food that		F 08	304	Food Temps are now within R	ange	05/06/2025
					How the facility will identify		
	_	able temperature for 1 of 1			other residents having the		
	trays tested for food	i temperature.			potential to be affected by th	е	
	Findings include:				same deficient practice:		
	On 4/7/35 at 12:50 P.M., a hall tray was obtained				·All residents have the poter	ntial	
					to be affected by the same alle		
		e following temperatures were			deficient practice	-9	
	observed:				. Dietary Staff educated on	the	
					Facility's Food Temperature		
	Carrots-115 degrees	s F			Policy to ensure ongoing		
		1/5/25 12 .15 .1 .5			compliance		
	_	on 4/7/25 at 12:45, the Dietary			M	_	
	-	that the holding temperatures hould be 145 degrees F or			Measures the facility will take to ensure that the problem w		
	higher.	mound be 145 degrees I of			be corrected and will not rec		
	mgner.				be corrected and will not rec	ui.	
	On 4/9/25 at 12:14	P.M., The Director of Nursing			·Dietary Staff educated on th	ne	
	(DON) provided a c	current, non-dated policy			Facility's Food Temperature		
	_	Temperatures for Meal			Policy.		
	Service." The policy						
	-	e monitored to prevent			Quality assurance plans to		
		nd ensure foods are served at			monitor facility performance		
		resserving/holding e 140 minimum when checked			make sure that corrections a achieved and are permanent	-	
		emeals that are served on			acinieveu anu are permanent	•	
	*	hot foods to be at 120 degrees			Dietary manager/designe	e	
		palatability for the resident"			will perform checks of food		
					temperatures 5 times a week	for	
	This citation relates	to Complaint IN00449780.			12 weeks to ensure food is be	ing	
					served at appropriate		
	3.1-21(a)(2)				temperatures.		
1			1		1		I

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

PRINTED: 05/06/2025 FORM APPROVED OMB NO. 0938-039

	OF CORRECTION	IDENTIFICATION NUMBER 155820		JILDING	00	COMPL 04/09/	ETED
	PROVIDER OR SUPPLIER N CARE LINCOLN			1236 LI	ADDRESS, CITY, STATE, ZIP COD NCOLN AVE VILLE, IN 47714		
(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)	ΓE	(X5) COMPLETION DATE
					The results of the above audits will be reviewed in the Quality Assurance Meeting monthly until 100% compliance achieved for 3 consecutive months. The QAA Committee identify any trends or patterns make recommendations to rev the plan of correction as indicated.	will and	
F 0812 SS=F Bldg. 00	Based on observation review, the facility	e/Prepare/Serve-Sanitary on, interview, and record failed to ensure food was anner for 1 of 2 kitchen	F 08	812	Immediate actions taken for those residents identified		05/06/2025
		containers were not labeled in ator and dry storage.			The bag of Zita noodles were discarded The bag of Marshmallows were discarded	e	
	On 4/3/25 at 10:35 at observed in the dry - One bag of Zita no	A.M., the following was storage area: podles with no open date nallows with no open date			The container of Orange Juice discarded The container of Apple Juice widdiscarded The Green container orange colored fluid was discared		
	On 4/3/25 at 10:57 at observed in the reaction of the container of the organization of the container of a preparation date or a preparation date or a preparation date or a preparation date or a container of a preparation date or a container of a preparation date or a container or a containe	orange juice without use by date pple juice without a			The pink container the brown colored fluid was discarded The clear container purple col fluid was discarded Two additional green colored containers fluid was discarded		
	without a label, prepared one pink containe without a label, prepared one clear containe without a label, prepared one clear containe without a label, prepared one clear containe without a label, prepared on the contained on th	er with orange colored fluid paration date, or use by date r with brown colored fluid paration date, or use by date er with purple colored fluid paration date, or use by date date date date.			The yellow container fluid was discarded 2 All residents have potentia be affected by alleged deficien practice. All Dietary Staff have been	al to	

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155820	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 04/09/2025
	PROVIDER OR SUPPLIER	2	1236 L	ADDRESS, CITY, STATE, ZIP COD INCOLN AVE SVILLE, IN 47714	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE CY 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 APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
		date, or use by date iner with fluid, without a label, use by date		educated on Proper Food Sto and the Facility's Labeling an Dating Foods Policy.	•
	Dietary Manager in labeled and have a positive of the control of the labeled and have a positive of the control of the labeled and have a provided a current, storage (Dry, Refripolicy indicated " including all food in	y on 4/8/25 at 9:31 A.M., the dicated containers should be preparation and use by date. P.M., the Director of Nursing non-dated policy "Food gerated, and Frozen." The the general storage guidelines tems will be labeled. The label me of the food and the date it ed by"		3) Measures put into place/ System changes: All Dietary Staff have been educated on Proper Food Sto and the Facility's Labeling an Dating Foods Policy. 4) How the corrective action will be monitored: ADM/Designee will complete random 5 observations a wee 12 weeks to ensure proper for handling and storage. The results of these interviewill be reviewed in Quality Assurance Meeting monthly	d ss ek for od ws
				months or until an average of 100% compliance or greater achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise plan of correction as indicated	the
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4) Infection Prevention				
	interview, the facili	on, record review, and ty failed to ensure infection ere implemented for 2 of 3	F 0880	Immediate actions taken those residents identified:	05/06/2025

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155820		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 04/09/2025		
	ROVIDER OR SUPPLIER		123	6 LI	ADDRESS, CITY, STATE, ZIP COD NCOLN AVE VILLE, IN 47714	•	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFI	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	(X5) COMPLETION
TAG		LSC IDENTIFYING INFORMATION For care. Gloves were not	TAG	ł	Resident 22 is receiving		DATE
		ygiene was not performed.			incontinence care per policy.		
	Findings include:				Resident 22 has been assess with no negative outcome not		
		2 A.M., incontinence care was			Resident F is receiving Woun	d	
	observed for Resident 22. CNA 23 sanitized with hand sanitizer and donned gloves while RN 28				Care per policy.		
	only donned gloves. CNA 23 gathered supplies				Resident F has been assesse		
	with the gloves on, turned the resident to the right side, and removed the resident's sweatpants and				with no negative outcome not	ed.	
	soiled brief. CNA 23 provided incontinence care				2) How the facility identified		
	using three wash cloths and turned the resident to the left side, then RN 28 completed the				other residents:		
		rith two more washcloths. RN			All residents have the potentia		
		ed gloves and washed hands : CNA 23 utilized the same			be affected by the alleged def		
	_	ier cream on Resident 22. CNA			practice.		
		l hands with the barrier clean			Nursing staff have been		
		ontinence brief and then put			reeducated on the Facilitys'		
		nce brief on Resident 22. 2.			Infection Control & Prevention	ו	
	_	on of wound care on 4/9/25 at gathered supplied and entered			Policy including sanitizing of hands, changing of gloves,		
		RN 7 applied hand sanitizer,		incontinence care and wound			
		ves on, and cut Resident F's			care.		
	dressing off. The dr	essing was dated 4/7. RN 7					
		with wound cleanser on					
		prep, HydraLock SA), and wrapped the left foot in			3) Measures put into place/		
	,). RN 7 taped the Kerlex in			System changes:		
		dressing 4/9, removed her			Nursing staff have been		
	_	ut a new pair of gloves on,			reeducated on the Facilitys'		
		on Resident F's left foot. RN 7			Infection Control & Prevention	า	
		gloves, and exited Resident F's			Policy including sanitizing of		
		perform hand hygiene during			hands, changing of gloves,		
	or after performing	wound care.			incontinence care and wound	care	
	_	on 4/9/25 at 9:37 A.M., the nist Nurse indicated that			4) How the corrective action will be monitored:	s	

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	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE C A. BUILDING		(X3) DATE SURVEY COMPLETED
AND PLAN	OF CORRECTION	155820	A. BUILDING B. WING	00	04/09/2025
APERION (X4) ID		STATEMENT OF DEFICIENCIE	1236 L EVAN	ADDRESS, CITY, STATE, ZIP COD LINCOLN AVE SVILLE, IN 47714 PROVIDERS PLAN OF CORRECTION (FACH CORRECTION SHOULD BE	(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION DATE
F 0882	gloves should be changed and hand hygiene should be performed when visibly soiled and in between going from dirty to clean tasks. On 4/9/25 at 12:14 P.M., the Director of Nursing (DON) provided a current, revised 1/31/18 "Glove Use- Nursing" The policy indicated " non-sterile gloves shall be worn for procedures involving contact with mucus membranes and for resident carerequiring direct contact with body fluidsexamples may include incontinence carehandling of linens, clothing, or other materials soiled with body fluids or blood Gloves used for contact shall be removed and discarded with each person. fluid item or surface Hand hygiene will be performed after removing gloves" 3.1-18(b)(1)			DON/Designee will complete sobservations of peri care a week for 4 weeks then 5 observation peri care 3 times a week for 8 weeks to ensure appropriate hygiene and glove changing. DON/Designee will complete sobservations of dressing channal a week for 4 weeks then 5 observations of dressing channal 3 times a week for 8 weeks to ensure appropriate hand hygien and glove changing. The results of these audits were be reviewed in Quality Assurance Meeting monthly months or until an average of 100 % compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise to plan of correction as indicated.	5 eek ens of eand 5 ges ges ene vill x6 of er
SS=F Bldg. 00	483.80(b)(1)-(4) Infection Prevention	onist Qualifications/Role			
	failed to ensure desi Preventionist (IP). I dedicate at least par for 1 of 1 staff mem Finding includes:	and record review, the facility ignation of a certified Infection The IP did not currently time hours to the role of IP abers reviewed for IP.	F 0882	1) Immediate actions taken for those residents identified: The Facility has Designated Infection Control Preventionist place for all residents. 2) How the facility identified	
	On 4/9/25 at 9:30 A	.M., the DON's employee file	1	other residents:	1

	AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING D B. WING O 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		(X3) DATE SURVEY COMPLETED 04/09/2025		
	PROVIDER OR SUPPLIER	2	1236 L	ADDRESS, CITY, STATE, ZIP COD INCOLN AVE SVILLE, IN 47714	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	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 APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	job description for role. On 4/9/25 at 9:37 A was currently respo	a.M., the DON indicated she insible for the infection trol program in the facility. She worked full time in the facility		All residents have the potential be affected by the alleged designation. An IP Nurse has been hired 3) Measures put into place/	
	as the DON.	P.M., the DON provided a		System changes: An IP Nurse has been hired	
	dated 4/14/22, that of Nursing and/or A Infection Prevention prevention and consurveillance, invest control of healthcar other infectious discontrol of 4/9/25 at 12:14 current Director of	igation, prevention, and re-associated infections and reases". P.M., the DON provided a Nursing job description, dated		4) How the corrective action will be monitored: The ADM/Designee will review/discuss weekly times twelve weeks the current stat the Infection Control Process. The results of these audits will reviewed in Quality Assurance.	us of es. Il be e
5/2/17, that indicated "The pri Director of Nursing position is develop and direct the overall Nursing Department in accord		the overall operation of our at in accordance with current ocal standards, guidelines, and		Meeting monthly x3 months of until an average of _100 % compliance or greater is achie x3 consecutive months. The Committee will identify any tre or patterns and make recommendations to revise the plan of correction as indicated	eved QA ends
F 9999					
Bldg. 00	education and train advance for all pers	n organized ongoing in-service ing program planned in connel. This training shall limited to, the following:	F 9999	Immediate actions taken to those residents identified: No Resident has been affected the alleged deficient practice.	ed by

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Event ID:

V9TI11

Facility ID: 000443

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	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	ì		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		ILDING	00	COMPLETED	
		155820	B. WI	NG		04/09/2025	
NAME OF F	PROVIDER OR SUPPLIER	·	•		ADDRESS, CITY, STATE, ZIP COD		
					INCOLN AVE		
APERIO	N CARE LINCOLN			<u>EVANS</u>	SVILLE, IN 47714		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	CY MUST BE PRECEDED BY FULL	1	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLET:	ION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE	
	(1) Residents' rights				2) How the facility identified		
	(4) Safety and accid	lent prevention			other residents:		
	This state rule was i	not met as evidenced by:			All residents have the potential	l to	
	This state rule was	not flet as evidenced by.			be affected by the alleged def		
	Based on interview	and record review, the facility			practice.	Sioni	
	failed to maintain personnel records 7 of 10 staff						
	members reviewed.	(LPN 20, Receptionist, CNA			Staff have completed the requ	ired	
	19, Minimum Data Set (MDS) Coordinator, CNA				Training.		
	21, RN 4, RN 7)						
					3) Measures put into place/		
	Findings include:				System changes:		
	On 4/9/25 at 9:30 A.M., employee files were				Staff have completed the requ	ired	
		loyee files for LPN 20,			Training.		
	-	19, MDS Coordinator, CNA 21,					
	RN 4, and RN 7 lac	ked documentation of			4) How the corrective actions	;	
	completed in-servic	es related to residents' rights			will be monitored:		
	and abuse after the	employee's start date.					
					Administrator will complete		
	~	y on 4/9/25 at 12:30 P.M., the			employee file reviews a weel		
		rirector indicated staff needed	for 12 weeks to ensure ongoing			ng	
	one hour of resident	t rights training.			compliance.		
	3.1-14 PERSONNE	EL			Identified concerns will be		
					addressed timely and		
	(u) In addition to th	e required in-service hours in			discussed in scheduled		
	` '	who have regular contact with			morning meetings.		
	* * * * * * * * * * * * * * * * * * * *	a minimum of six (6) hours of					
	dementia-specific tr	raining within six (6) months of					
	initial employment,	or within thirty (30) days for					
	personnel assigned	to the Alzheimer's and					
	_	re unit, and three (3) hours			The results of these audits w	ill	
	-	to meet the needs or			be reviewed in Quality		
	_	, of cognitively impaired			Assurance Meeting monthly		
	_	n understanding of the current			months or until an average of		
	standards of care fo	r residents with dementia.			100 % compliance or greate	r	
					is achieved x3 consecutive		
	This state rule was i	not met as evidenced by:			months. The QA Committee		
			ı		will identify any trends or		

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

PRINTED: 05/06/2025 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155820	A. B	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 04/09/2025	
NAME OF PROVIDER OR SUPPLIER APERION CARE LINCOLN				STREET ADDRESS, CITY, STATE, ZIP COD 1236 LINCOLN AVE EVANSVILLE, IN 47714				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION Based on interview and record review, the facility failed to ensure dementia training was completed for 5 of 10 staff members reviewed. (CNA 19, MDS Coordinator, CNA 21, RN 4, RN 7)			ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (BACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMP.		(X5) COMPLETION DATE	
					patterns and make recommendations to revise the plan of correction as indicated.			
	Findings include:							
	reviewed. The emp Coordinator, CNA	A.M., employee files were loyee files for CNA 19, MDS 21, RN 4, and RN 7 lacked completed in-service related g.						
	- MDS Coordinator training. - CNA 21 lacked 6 - RN 4 lacked 6 hou	hours of dementia training. clacked 3 hours of dementia hours of dementia training. urs of dementia training. urs of dementia training.						
	Human Resource D aware of how many	y on 4/9/25 at 12:30 P.M., the Director indicated she was not a dementia in services hours ally, but six hours were res.						
	Administrator indic	y on 4/9/25 at 2:00 P.M., the cated the facility had no policy mount of inservices hours mentia training.						

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