This visit was for the Investigation of Complaints IN00305645 and IN00305653.

Complaint IN00305645 - Substantiated. Federal/state deficiency related to the allegation is cited at F725.

Complaint IN00305653 - Substantiated. Federal/state deficiency related to the allegation is cited at F725.

Unrelated deficiencies are cited.

Survey dates: September 9 and 10, 2019

Facility number: 012809
Provider number: 155799
AIM number: 201136580

Census Bed Type:
SNF/NF: 37
SNF: 7
Residential: 15
Total: 59

Census Payor Type:
Medicare: 10
Medicaid: 29
Other: 5
Total: 44

These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1

Quality review completed on September 13, 2019.
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

NAME OF PROVIDER OR SUPPLIER
APERION CARE MARION LLC

STREET ADDRESS, CITY, STATE, ZIP CODE
614 WEST 14TH STREET
MARION, IN 46953

Please feel free to call me with any further questions at (765)662-3701.

Respectfully submitted,
Joshua Davis HFA
Executive Director

483.10(f)(5)(i)-(iv)(6)(7)
Resident/Family Group and Response

§483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility.
(i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner.
(ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group’s invitation.
(iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings.
(iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility.
(A) The facility must be able to demonstrate their response and rationale for such response.
(B) This should not be construed to mean...
<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>Summary Statement of Deficiency</th>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>Provider's Plan of Correction</th>
<th>Completion Date</th>
</tr>
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<tbody>
<tr>
<td>F 0565</td>
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<td>that the facility must implement as recommended every request of the resident or family group.</td>
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<td>§483.10(f)(6) The resident has a right to participate in family groups.</td>
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<td>§483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. Based on observation and interview, the facility failed to provide written documentation from the resident council meetings and failed to provide their response to any grievance that may have been made. Findings include: On 9/10/19 at 10:05 a.m., the Resident Council President gave permission to review the minutes from the meeting. The Activity Director (AD) was present and indicated she would provide the book. On 9/10/19 at 10:18 a.m., the AD indicated she was unable to find the book and thought the corporate person had the book. At 10:32 a.m., the Administrator indicated he did not have the resident council book and the AD was currently looking for the book. During an interview on 9/10/19 at 12:53 p.m., the AD indicated she was unable to find the resident council book containing the meeting minutes. Review of a Resident and Family Handbook, provided by the Assistant Director of Nursing on</td>
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<td>10/01/2019</td>
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Resident council meeting was held to determine concerns were reviewed and responses were timely. Any concerns were immediately addressed.

**Measures put into place/**

**Systemic changes:**
The Activity Director or designee will scan meeting minutes made during Resident Council meeting into an electronic file (Resident Council Minutes) to be kept as back up records prior to being filed in resident council book. Grievances will be recorded on facility grievance forms and kept per Social Services.

**How the corrective actions will be monitored:**
Administrator or designee will audit resident council book and electronic files monthly to assure verification of meeting minutes and a backup copy of meeting minutes has been scanned into electronic file. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.
The facility must ensure that -
§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and

§483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents.

Based on interview and record review, the facility failed to provide adequate supervision and interventions to prevent the use of illicit drugs for 1 of 3 residents reviewed for accidents (Resident F).

Findings include:

During an interview on 9/9/19 at 9:47 a.m., Resident F indicated she had recently used heroin (opioid drug). She indicated she bought it and would not say where she got the drug from. She was in constant pain and was currently taking Lortab (hydrocodone bitartrate and acetaminophen tablets). She wanted to stay in the facility and agreed to follow the rules. She has struggled with pain and medications since the 1980's.

The clinical record for Resident F was reviewed on 9/9/19 at 10:30 a.m. Diagnoses included, but were not limited to, fibromyalgia, osteoarthritis, anxiety, chronic obstructive pulmonary disease and cognitive communication deficit.

A history and physical, dated 2/21/19, indicated the resident presented to the emergency room complaining of pain and being unable to walk. The past medical history included, but was not limited to, additions, heroin and tobacco use.

Resident F was admitted to the facility on 2/24/19.

Immediate action taken for those residents identified:
Behavioral contract was signed with the resident. Resident F will be placed on 15 min safety and behavioral checks. Resident F was re-educated on signing out in the LOA binder prior to leaving the facility. Physician notified of current monitoring status and behavioral contract. Medication review requested by pharmacy. Resident F care plan was reviewed and revised.

How the facility identified other...
A current health care plan, dated 9/9/19, indicated the resident had a history of non-prescription drug use while in the facility. Interventions included, but were not limited to, had signed a contract with the facility regarding the behavior and potential discharge.

A Social Service progress note, dated 7/4/19 at 1:05 p.m., indicated the therapy department noted slurred speech, nonsensical conversation and half closed, droopy eyes. The resident was slumped over the stationary bike with her eyes half opened. The resident indicated she had just taken a muscle relaxant and it had made her sleepy. Her speech was slurred and difficult to understand. A nurse was assessing the resident and noted suspected drug use. The resident had a visitor just prior to going to therapy. The nurse indicated the resident received her muscle relaxant and pain pill at 11:00 a.m.

On 7/5/19 at 10:50 p.m., the resident had just returned from Leave of Absence (LOA) and while getting into bed, a nurse found a syringe laying on her bed, under the shirt the resident had just taken off. The resident indicated she found it earlier and it must have come from her purse from a long time ago. The nurse notified the Assistant Director of Nursing (ADON). A urine drug screen was requested from the resident and she refused stating she would be kicked out of the facility. The resident continued to deny having any illegal drugs in her system and refused the drug screen.

The most recent admission Minimum Data Set (MDS), dated 6/27/19, indicated the resident was cognitively intact. She used a walker and wheelchair for mobility.

Measures put into place/
Systemic changes:
Nursing staff was in serviced on timely documentation, completing vital signs daily, care plan interventions, monitoring changes in conditions of residents, and monitor of LOA book for residence that are leaving facility. Any changes in condition noted on a resident with suspected drug use will be documented appropriately and MD will be notified of changes in condition and will be sent out for further evaluation and treatment of changes in condition. Any resident admitted with a history of active drug use will be encouraged to sign a behavioral contract. Residents identified to require additional supervision will be placed of 15 min observations per nursing for 72 hours initially then reviewed by the IDT for continued supervision as needed. Those residents requiring additional supervision will be discussed in scheduled morning/clinical meetings Care plan will reflect any increased supervision. Monitoring of documentation required for safety/behavioral monitoring will be
<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCY</th>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
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<td></td>
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<td>On 7/6/19 at 5:38 a.m., the resident consented to the drug screen and urine was collected.</td>
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<td>the responsibility of the Director of Nursing/designee.</td>
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<td>On 7/8/19 at 11:57 a.m., the Social Service Director (SSD) met with the resident related to suspected drug use over the weekend. The resident appeared almost delirious, slurring her words, whimpering, unable to keep eyes opened or focused. The resident was begging the SSD to &quot;do something.&quot; She did not want to discharge or miss out on therapy. She swore she was not using drugs and asked if she could do out patient therapy. The resident requested Home Health Care (HHC), but did not have an address to give. The SSD indicated she could not set up HHC without an address.</td>
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<td>How the corrective actions will be monitored: DON or Designee will audit 24 hour summary report for noted changes in conditions daily during regular scheduled morning and clinical meetings. Identified changed will be reported to the Director of Nursing/designee and the physician promptly with noted documentation. Care plans will be reviewed and updated for those residents identified to have had a change in condition to ensure interventions were updated to include appropriate supervision. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.</td>
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<td>On 7/8/19 at 1:46 p.m., a Nurse Practitioner (NP) progress note indicated the resident denied taking more narcotics than her scheduled dose. The resident stated &quot;you are not running anything on me.&quot; The plan indicated the resident refused drug testing.</td>
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<td>On 7/9/19 at 6:05 p.m., the resident was noted to be slurring her words and unable to move herself. She was not making sense and could not keep her eyes open. The facility called 911.</td>
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<td>On 7/9/19 at 6:10 p.m., the Director of Nursing (DON) instructed the nurse to ask permission to search her room. The resident refused and the DON was notified of the refusal.</td>
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<td>On 7/16/19 at 1:00 p.m., the resident had an unwitnessed fall in her room. The resident was sent to the local hospital for evaluation and treatment.</td>
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On 7/16/19 at 10:47 p.m., the hospital called to notify the facility the resident had tested positive for opiates and amphetamines.

An Interdisciplinary Team (IDT) meeting on 7/17/19 at 9:30 a.m., indicated no new interventions were put into place following non-prescription drugs found in the resident's room.

The resident returned to the facility on 7/19/19 at 4:54 p.m.

On 7/26/19 at 1:46 p.m., the SSD received a Notice of Non-Coverage, dated 8/1/19. The SSD explained the notice to the resident. She burst into tears and stated she did not know where she was going to go. The resident was looking at placement with a family member.

A SSD progress note, dated 9/3/19 at 10:22 a.m., it was reported that the resident daughter and a male friend had spent the night in the resident's room. The Administrator spoke to the daughter and informed her she was welcome to visit, anytime day or night but she was not allowed to spend the night, take a shower or eat the resident's food. The daughter acknowledged this and said she did not have a ride to get home last night and that was the only reason why she and her friend stayed.

A change of condition was noted on 9/6/19. The resident had abnormal vital signs, altered mental status and behavioral symptoms. She was slurring words and unable to keep her eyes open. The resident was sent to the hospital.

On 9/6/19, the resident was admitted to the hospital for toxidrome (syndrome caused by a
dangerous level of toxins in the body) related to substance abuse. The resident admitted from a long term care facility with low blood pressure. The resident was in denial about her substance use and was not a candidate for any type of addiction rehabilitation. The impression/plan indicated hypotension due to drugs, believed secondary to heroin. The patient had a history of chronic past abuse.

A late entry progress noted, dated 9/8/19 at 9:28 a.m., indicated the SSD spoke with the resident related to the recent hospitalization and toxicology report, which indicated she tested positive for illicit drugs. The resident denied taking drugs before going to the emergency room, but did admit she had taken them prior. The resident voiced understanding if any drugs, syringes, tourniquets or pills were found in her room, it would result in a 30-day involuntary discharge.

During an interview on 9/9/19 at 9:36, the Administrator indicated he long suspected the resident of self-medicating, usually after the family left. The resident was a full-code and had really low blood pressure. They called the hospital and he later received a call from the Emergency Room (ER) physician asking what may be wrong with her because all of the tests were normal. The Administrator indicated to to the physician to maybe run a drug screen. The ER physician called back and indicated she had tested positive for opioid use. Both him and the DON spoke to the resident this morning and had her sign a behavior contract. If the resident was found with any drugs, she would then be issued a 30-day discharge notice. The resident was aware the facility suspects the family of providing her with drugs. No police have been involved.
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**IDENTIFICATION NUMBER**

<table>
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<tr>
<th>X1) PROVIDER/SUPPLIER/CLIA</th>
<th>X2) MULTIPLE CONSTRUCTION</th>
<th>X3) DATE SURVEY</th>
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<tr>
<td>ID</td>
<td>A. BUILDING 00</td>
<td>COMPLETED 09/10/2019</td>
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<td>B. WING</td>
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</table>

**NAME OF PROVIDER OR SUPPLIER**

APERION CARE MARION LLC

**STREET ADDRESS, CITY, STATE, ZIP CODE**

614 WEST 14TH STREET
MARION, IN 46953

**SUMMARY STATEMENT OF DEFICIENCY**

On 9/10/19 at 2:02 p.m., the ADON indicated the resident was her own person, alert and oriented and could sign herself out.

Review of the Release of Responsibility for Leave of Absence, provided by the Director of Nursing on 9/10/19 at 2:10 p.m., indicated Resident F did not sign herself out on 9/6/19.

Review of a Resident and Family Handbook, provided by the Assistant Director of Nursing on 9/10/19 at 2:07 p.m., indicated the following:

"RESIDENT RESPONSIBILITIES

8. Residents may not leave the premises without signing out at their respective nurse's station...."

3.1-45(a)(2)

483.35(a)(1)(2)

Sufficient Nursing Staff

§483.35(a) Sufficient Staff.

The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e).

§483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:
### Statement of Deficiencies and Plan of Correction

#### Identification Number
155799

#### Multiple Construction

<table>
<thead>
<tr>
<th>A. Building</th>
<th>B. Wing</th>
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#### Date Survey Completed
09/10/2019

### Name of Provider or Supplier
APERION CARE MARION LLC

### Street Address, City, State, Zip Code
614 WEST 14TH STREET
MARION, IN 46953

### Summary Statement of Deficiency

<table>
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<tr>
<th>ID</th>
<th>Prefix</th>
<th>Tag</th>
<th>(Each Deficiency Must Be Preceded By Full Regulatory Or LSC Identifying Information)</th>
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<tr>
<td></td>
<td>F</td>
<td>0725</td>
<td>F 725 Sufficient Nursing Staff</td>
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</table>

#### Findings Include:

1. During an interview on 9/9/19 at 4:30 a.m., Resident C continued to voice being upset that she did not get her shower. She indicated it took a long time to get someone to help you.

2. During an observation and interview on 9/9/19 at 9:59 a.m., Resident F indicated the towels on the bathroom floor had been there since 5:00 a.m. She indicated the aide told her the day shift aide would get them. Staff were often on their phones rather than helping the residents.

3. During an interview on 9/9/19 at 10:46 a.m., Resident B indicated the facility did not have enough staff to meet his needs. He was not getting his showers as scheduled, but did receive one today. Call lights take longer than 15 minutes to answer.

4. During a family interview on 9/10/19 at 9:31

#### Immediate Actions taken for those residents identified:
Facility resident interviews were conducted with those individuals with BIMS score 11 or greater to identify concerns regarding provision of showers, call light response times, cell phone usage, and grievance response times.
a.m., she indicated she was in the facility several times a week. She had filled out several grievance forms and management does not always get back with her. She had several complaints related to care. She would often find her mother's linens wet and she would have urine soaked through her clothing. She would also come in and find her mother had not been up yet in the morning, shades were still closed and the television was not on. This bothered her because her mother could not see, but could hear. They were often short staffed and the place often had a strong smell of urine.

5. During an interview on 9/10/19 at 12:10 p.m., Resident H indicated his medications were often late and it took a long time for anyone to answer the call lights. There were not enough people in the building to help with his needs.

During an interview on 9/9/19 at 7:56 a.m., RN 7 indicated she was the only nurse on the floor today. She had a QMA on AL-Hall and D-Hall. Another QMA was scheduled to be on E-Hall at 8:00 a.m. She also had a trainee with her. She would be required to give all the insulin and treatments that a QMA could not do.

During an observation on 9/9/19 at 10:49 a.m., LPN 6 was observed to get a glucometer from the medication cart and go into a resident's room. She proceeded to obtain a blood glucose level. She exited to room, cleaned the machine and proceeded to enter another resident's room. She obtained another blood glucose level.

During an interview on 9/9/19 at 10:55 a.m., LPN 6 indicated today was her first day and she was helping the nurse get some stuff done.
### STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

**NAME OF PROVIDER OR SUPPLIER**
APERION CARE MARION LLC

**STREET ADDRESS, CITY, STATE, ZIP CODE**
614 WEST 14TH STREET
MARION, IN 46953

<table>
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<tr>
<th>(X4) ID</th>
<th>SUMMARY STATEMENT OF DEFICIENCY</th>
<th>ID</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
<th>(X5) COMPLETION DATE</th>
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<tbody>
<tr>
<td>PREFIX</td>
<td>(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</td>
<td>PREFIX</td>
<td>(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCES TO THE APPROPRIATE DEFICIENCY)</td>
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**At 10:58 a.m., the Assistant Director of Nursing (ADON) asked LPN 6 where the nurse was. The ADON indicated to LPN 6 she should be with the nurse wherever she went since today was her first day. LPN 6 indicated to the ADON she was just asked to get blood sugars.**

Review of LPN 6's Orientation Competency form, provided by the Administrator on 9/10/19 at 11:39 a.m., the only competency checked-off was for glucometer use and cleaning.

During an observation on 9/9/19 at 11:21 a.m., Qualified Medication Aide 4 was at the medication cart and the medication administration screen was visible. Several medications were colored red on the screen. The red screen indicated the administration documentation was overdue. She indicated she came over from the Assisted Living side to help pass medications. She was unsure of the time the medications were to be given.

A Medication Administration Audit Report was provided by the ADON on 9/9/19 at 11:42 a.m. The form was printed at 11:35 a.m. A total of 78, 7:00 a.m. medications were not given within the one-hour time frame on E-Hall. The medications, included, but were not limited to, levetiracetam (seizure disorder), amlodipine (to treat high blood pressure), fluoxetine (antidepressant), glimepiride (oral diabetes medicine), Toprol XL (for treating high blood pressure), hydrochlorothiazide (to treat fluid retention), Flomax (to treat benign prostatic hyperplasia), Lyrica (to treat pain), Lantus (long acting insulin) and Humalog (rapid-acting insulin).

Review of the day shift, daily staffing sheet from 8/26/19 through 9/9/19, indicated one nurse was scheduled for three halls during the day on 4 administration. Focus on signing medications off at the time of administration.

Education Provided on Grievance Process and Cell Phone Usage

Education provided on call light response time

Facility rounding will be completed daily during Angel rounds for identification of Facility odors. Areas identified will be brought to the attention of the Administrator for delegation of correction

1. How the corrective actions will be monitored:

   Daily review during morning meeting, of staffing patterns to determine enough staff is scheduled to meet resident needs per Administrator, Director of Nursing and scheduler.

   Director of Nursing/designee will randomly audit weekly through observation and interview, (to include all shifts) concerns related to provision of care, call light response times, cell phone usage and grievance response times. Identified issues will be addressed timely.

   Observation of medication administration and documentation 3 times weekly (to include all shifts) per Director of Nursing/designee.
Review of the Medication Administration Audit Report, provided by the Assistant Director of Nursing on 9/10/19 at 12:55 p.m., indicated medications were given outside the one-hour limit. The medications included, but were not limited to,

<table>
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<tr>
<th>Occasion</th>
<th>Medication Description</th>
<th>Scheduled Time</th>
<th>Given Time</th>
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<tbody>
<tr>
<td>9/1/19</td>
<td>Humalog (insulin)</td>
<td>6:30 a.m.</td>
<td>9:18 a.m.</td>
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<tr>
<td>9/1/19</td>
<td>Lexapro (treat depression)</td>
<td>6:00 a.m.</td>
<td>8:58 a.m.</td>
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<tr>
<td>9/1/19</td>
<td>Combivent (bronchodilator)</td>
<td>7:00 a.m.</td>
<td>11:11 a.m.</td>
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<tr>
<td>9/5/19</td>
<td>Novolog (insulin)</td>
<td>6:00 a.m.</td>
<td>8:45 a.m.</td>
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<tr>
<td>9/5/19</td>
<td>Gabapentin (anti-epileptic drug)</td>
<td>7:00 a.m.</td>
<td>9:50 a.m.</td>
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<tr>
<td>9/5/19</td>
<td>Zoloft (treat major depression)</td>
<td>7:00 a.m.</td>
<td>1:15 p.m.</td>
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<tr>
<td>9/5/19</td>
<td>Vancomycin, intravenous (treat infections)</td>
<td>7:00 a.m.</td>
<td>10:58 a.m.</td>
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<tr>
<td>9/5/19</td>
<td>Oxycodeine (relieve moderate to severe pain)</td>
<td>8:00 a.m.</td>
<td>10:32 a.m.</td>
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<tr>
<td>9/5/19</td>
<td>Norco (hydrocodone-acetaminophen)</td>
<td>8:00 a.m.</td>
<td>1:13 p.m.</td>
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<tr>
<td>9/5/19</td>
<td>Ativan (treat anxiety)</td>
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these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.
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<td>EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY</td>
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<tr>
<td>10:00 a.m. and given at 1:13 p.m.</td>
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<td>l. On 9/6/19, vancomycin, ordered at 7:00 a.m. and given at 2:22 p.m.</td>
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<td>m. On 9/6/19, Humalog ordered at 7:00 a.m. and given at 9:06 a.m.</td>
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<td>n. On 9/6/19, levetiracetam ordered at 7:00 a.m. and given at 11:24 a.m.</td>
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<td>o. On 9/6/19, Cymbalta (antidepressant) ordered at 7:00 a.m. and given at 11:24 a.m.</td>
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Review of a Minimum Data Set (MDS) report, provided by the MDS Coordinator on 9/10/19 at 12:26 p.m., the health care facility had a total of 13 residents who required two-person assistance and 3 residents who were transferred using a mechanical lift.

Review of the Grievance Tracking Log from 8/1/19 through 9/3/19, the following concerns were voiced:

a. 8/5/19, a family member complained the call lights were not being answered timely.

b. 8/6/19, a family member complained that his family member, who resided in the facility, had concerns that were not taken seriously.

c. 8/23/19, a family member complained about medication concerns.

d. 8/29/19, a family member complained about a poor nursing interaction.

e. 9/7/19, a resident complained their catheter was not changed.

f. 9/3/19, a family member complained about nursing care concerns.

During an interview on 9/10/19 at 1:04 p.m., the Social Service Director (SSD) indicated on 8/5/19, the family complained the call lights were not being answered timely. On 8/6/19, the family was upset with residents treatment on his legs. On 8/23/19, the family was upset because the
Confidential interviews for staff were completed. Exact times and dates withheld to maintain anonymity.

Employee 8 indicated if they staff two aides on each side and a float on days, they could get their work done. Less than that was difficult.

Employee 9 indicated it was impossible the get all the medication administered, give the insulin and dressing changes for one nurse and 2 or 3 QMAs.

Employee 10 indicated the work could not get done with just one nurse and QMAs.

Employee 11 indicated it depended on who else was working. She was currently the only aide on the hall for a while.

Employee 12 indicated two aides on E-Hall were not enough because it had a higher acuity.

During an interview on 9/9/19 at 11:33 a.m., the ADON indicated the minimum was 1 nurse and 2 QMAs. Three where scheduled for today, but one called off. They have a total of 6 insulin dependent residents on E-Hall, 2 on D-Hall and 1 on AL-Hall.

On 9/9/19 at 11:40 a.m., the ADON indicated both herself and the Director of Nursing would take a medication cart. They may not take the whole cart, but do help on the floor. The last time she
took a medication cart was probably back in June.

During an interview n 9/10/19 at 11:24 a.m., the Administrator indicated they try to have a nurse or QMA on D-Hall, a nurse on E-Hall and also a float QMA to D and E-Hall. They always have 2 aides on each side. They would never staff a nurse on the assisted living side. There are no calculations for their staffing. The numbers come from the corporate office. They do not have any type of assessment tool for staffing. Both the DON and ADON are full time and could have helped the nurse who was behind on medication administration if she would have asked.

This Federal tag relates to Complaints IN00305653 and IN00305645.

3.1-17(a)

Resident Records - Identifiable Information

§483.20(f)(5) Resident-identifiable information.
(i) A facility may not release information that is resident-identifiable to the public.
(ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.

§483.70(i) Medical records.
§483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-
(i) Complete;
(ii) Accurately documented;
(iii) Readily accessible; and
§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(i)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when there is no requirement in State law; or
(iii) For a minor, 3 years after a resident reaches legal age under State law.

§483.70(i)(5) The medical record must contain-
(i) Sufficient information to identify the resident;
### Statement of Deficiencies and Plan ofCorrection

#### Identification Number
- **Provider Name:** APERION CARE MARION LLC
- **Address:** 614 WEST 14TH STREET, MARION, IN 46953

#### Summary Statement of Deficiency

<table>
<thead>
<tr>
<th>Deficiency Description</th>
<th>ID</th>
<th>Date</th>
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<td>(ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. Based on observation, interview, and record review, the facility failed to ensure residents' clinical information was maintained in a confidential manner for 3 random observations (E Hall). Findings include:</td>
<td>F 0842</td>
<td>10/01/2019</td>
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**The facility requests paper compliance for this citation.** This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.

**Immediate action taken for those residents identified:** Medication Records room and file cabinets were locked upon identification of being unlocked. Keys were given to appropriate staff for medical record room access. Door remained shut and locked.

**How the facility identified other residents:** All residents have the potential to be affected by this practice.
at 12:15 p.m., indicated the following:

"...Retention and Storage

1. All medical records are stored protected from loss, destruction, and unauthorized use. Records are so stored that information contained in the records is kept confidential...."

3.1-3(o)

**Measures put into place/**

**Systemic changes:**

Nursing staff was in serviced on proper storage of medical records. They were in serviced on proper storage of resident information/ HIPPA

**How the corrective actions will be monitored:**

Administrator/designee will observe for secured medical records 5 times weekly to include all shifts to ensure secure storage. Identified issues will be immediately addressed. Administrator/designee will through routine facility rounding to include all shifts observe for the security of resident information and potential HIPPA violations. File cabinets will remain locked in Medical Records room. The Results of these audits will be reviewed in Quality Assurance Meeting Monthly x6 months or until the average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.