STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155532	A. BUILDING 00 B. WING	10/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
APERION CARE MONROE	120 E MILLER DR BLOOMINGTON, IN 47401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: October 21, 22, 23, 24 and 25, 2024 Facility number: 000460 Provider number: 155532 AIM number: 100290620 Census Bed Type: SNF/NF: 35 Total: 35 Census Payor Type: Medicare: 2 Medicaid: 29 Other: 4 Total: 35 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed October 30, 2024.	F 0000	1 F000 By submitting the enclosed material, we are not admitting to the truth or accuracy of any specific binding or allegations. We reserve the right to contest the finding or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests the Plan of Correction be considered our allegation of compliance effective November 6th, 2024 for the annual recertification and state licensure. ="" span="">	
F 0623 SS=D Bldg. 00	483.15(c)(3)-(6)(8) Notice Requirements Before Transfer/Discharge Based on interview and record review, the facility failed to ensure the written notification required for a transfer and discharge was provided to the resident and the resident representative for 1 of 1 resident reviewed for hospitalization. (Resident 33) Findings include: Residents 33's clinical record was reviewed on	F 0623	F623 Notice Requirements Before Transfer/Discharge **The facility ensures the residents right to be notified of the requirements Before Transfer/Discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice**	11/06/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Faith Arvin	HFA	11/07/2024

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	10/22/24 at 2:02 p.m. The diagnoses included, but were not limited to, dementia and fracture of the left femur. Resident 33's progress notes indicated the resident was sent to the hospital on 9/30/24. The clinical record lacked documentation the written notification of the Transfer and Discharge forms were provided to the resident and the resident representative. During an interview on 10/24/24 at 2:45 p.m., the Administrator indicated the forms were sent in writing to the resident representative but was not documented. On 10/25/24 at 12:09 p.m., the Administrator provided the facility's policy,"Discharge Transfer of Resident," dated 11/28/12, and indicated it was the policy currently being used by the facility. A review of the policy did not indicate sending the written notification required for a transfer and discharge to the resident and the resident representative. 3.1-12(a)(6)(A)(i) 3.1-12(a)(6)(A)(iii)		**to a representative of the Office of the State Long-Term Care Ombudsman.** R33's clinical record was updated with late entry on 10/24/2024 from the day of visit with family at hospital with SSD, where family was given a copy of Transfer and Discharge Forms. All residents have the potential to be affected by this finding. DON and SSD were in serviced on 11/5/2024 on the importance of Transfer and Discharge forms, as well as proper documentation when mailing and/or giving to residents and representatives. Transfer and Discharge documentation as well as discharges, to be audited by SSD five days per week times four weeks, weekly times 4, and monthly x1. Any concerns will be addressed as discovered. If any patterns are identified at the monthly QAPI meeting an action plan will be written by the committee. Any written action plan will be monitored by the Admin and/or Designee monthly until resolved in substantial compliance is achieved.	
F 0625 SS=D	483.15(d)(1)(2) Notice of Bed Hold Policy Before/Upon Trnsfr			

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Bldg. 00	Based on interview and record review, the facility failed to ensure the notification of the bed hold policy required for a resident who transferred to the hospital was provided in writing to the resident or the resident representative for 1 of 1 resident reviewed for hospitalization. (Resident 33) Findings include: Residents 33's clinical record was reviewed on 10/22/24 at 2:02 p.m. The diagnoses included, but were not limited to, dementia and fracture of the left femur. Resident 33's progress notes indicated the resident was sent to the hospital on 9/30/24. The clinical record lacked documentation the written notification which specified the facility's bed hold policy was provided to the resident or the resident representative. During an interview on 10/24/24 at 2:45 p.m., the Administrator indicated the forms were sent in writing to the resident representative but was not documented. On 10/25/24 at 12:09 p.m., the Administrator provided the facility's policy,"Bed Hold and Return to Facility," dated 11/28/12, and indicated it was the policy currently being used by the facility. A review of the policy indicated, "... Guidelines: ... The facility bed hold policy will be given to the resident and/or resident representative as follows ... At the time of a transfer from the facility ... In cases of emergency transfer, notice [at time of transfer] means that the family or representative are provided with written notification within 24 hours of the transfer ..."	F 0625	F625 Notice of Bed Hold Policy Before/Upon Transfer **The facility ensures the residents right to be notified of the Bed Hold Policy/Upon Transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident and/or resident representative.** R33's clinical record was updated with late entry on 10/24/2024 from the day of visit with family at hospital with SSD, where family was given a copy of Bedhold Forms. All residents have the potential to be affected by this finding. DON and SSD were in serviced on 11/5/2024 of the importance of Bedhold Policy forms, as well as proper documentation when mailing and/or giving to residents and representatives. Bed Hold Policy documentation as well as discharges, to be audited by SSD five days per week times four weeks, weekly times 4, and monthly x1. Any concerns will be addressed as discovered. If any patterns are identified at the monthly QAPI meeting an action	11/06/2024

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	3.1-12(a)(25) 3.1-12(a)(26)		plan will be written by the committee. Any written action plan will be monitored by the Admin and/or Designee monthly until resolved in substantial compliance is achieved.	
F 0641 SS=D Bldg. 00	483.20(g) Accuracy of Assessments Based on interview and record review, the facility failed to ensure the accuracy of the Minimum Data Set (MDS) assessment for a 2 of 2 residents reviewed for nutrition. Weight loss and IV (intravenous) nutrition were coded inaccurately. (Resident 7, Resident 31) Findings include: 1. Resident 7's clinical record was reviewed on 10/25/24 at 10:00 a.m. The diagnosis included, but was not limited to, Alzheimer's Disease. A review of the Weights and Vitals Summary for Resident 7 indicated the following: -On 6/24/24, the resident weighed 116 pounds. -On 7/8/24, the resident weighed 110 pounds. -On 8/5/24, the resident weighed 109 pounds. -On 9/4/24, the resident weighed 105 pounds. -On 10/11/24, the resident weighed 101 pounds. This was an assessed 12.93% severe weight loss in 5 months.	F 0641	F641 Accuracy of Assessments **The facility ensures the resident rights of their assessments accurately reflecting the resident's status.** R7's MDS coding on weight was immediately corrected to include the correct and accurate weight on 10/25/2024. R31's MDS coding on IV (intravenous) nutrition was immediately corrected to include only tube feeding as ordered on 10/25/2024. All residents have the potential to be affected by this finding. IDT staff who do Admission MDS's in serviced on the importance of The Admission MDS Assessment and the accuracy of the information on 11/5/2024. IDT staff and the Dietary Manager in serviced on the importance of Accuracy of Assessments on	11/06/2024

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	Resident 7's Annual MDS assessment, dated 10/7/24, indicated the resident weighed 134 and weight loss had not been assessed during the look back period. During an interview on 10/25/24 at 10:15 a.m., the Assistant Director of Nursing indicated the Annual MDS assessment, dated 10/7/24, for Resident 7 had been coded incorrectly for the resident's weight loss and weight during the look back period. 2. On 10/22/24 at 1:43 p.m., Resident 31's clinical record was reviewed. The diagnoses included, but were not limited to, traumatic brain injury, dysphagia (swallowing difficulties), and respiratory failure. The Admission MDS assessment, dated 9/13/24, indicated the resident received Parenteral/IV (a method of providing nutrition directly into the bloodstream through a vein) and tube feedings (medical device used to provide nutrition to people who cannot obtain nutrition by mouth, are unable to swallow safely, or need nutritional supplementation) while a resident. The Physician's orders, dated 9/10/24, indicated the resident was receiving enteral feeding (tube feeding). During an interview with the DON on 10/25/24 at 9:40 a.m., the DON indicated the resident only had tube feedings and had not had IV feedings since admitted. During an interview with the Assistant Director of Nursing (ADON)/MDS Coordinator on 10/25/24 at 9:48 a.m., indicated that the resident never had an IV for feedings and the MDS assessment was marked incorrectly on admission.		11/5/2024. MDS Assessments will be audited five days per week times four weeks, weekly times 4, and monthly x1. Admission Assessments will be audited upon any admission or re-admission. Any concerns will be addressed as discovered. If any patterns are identified at the monthly QAPI meeting an action plan will be written by the committee. Any written action plan will be monitored by the Admin and/or Designee monthly until resolved in substantial compliance is achieved.	

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	During an interview with the Administrator on 10/25/24 at 10:05 a.m., she indicated they did not have a MDS assessment coding policy. They followed the Resident Assessment Instrument (RAI) manual for coding the MDS assessment. 3.1-31(d)			
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals Based on observation, interview, and record review, the facility failed to label medications with an open and expiration dates for 1 of 1 medication rooms observed. (Medication Room, Resident 14) Findings include: On 10/24/24 at 11:00 a.m., the refrigerator in the medication room was observed to have a vial of tuberculin PPD (purified protein derivative, a solution to aid in diagnosis of a tuberculosis infection) without an open or expiration date. An Ozempic injector pen (an injectable medication used to treat type 2 diabetes) for Resident 14, was observed without an open date or an expiration date. The Director of Nursing (DON) could not find an open date or an expiration date on either medication. The DON indicated every medication that was opened should have an open date and an expiration date on the vial or the pen. The DON was unsure when to discard medications after they were opened. On 10/24/24 at 11:25 a.m., the Administrator provided the facility's policy on "Medication Storage", dated 7/2/19, and indicated it was a current policy being used by the facility. A review of the policy indicated "...5. Once any medication... is opened, facility should follow	F 0761	F761 Label/Store Drugs and Biologicals **The facility ensures that all stored drugs and biologicals are labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.** The opened, undated, tuberculin PPD and Ozempic Injector Pen was discarded and replaced on 10/24/2024 with a new vial and pen and was dated when opened. All residents have the potential to be affected by this finding. Corrections were completed as audits were conducted. No adverse actions were noted with this finding. All medications in the Medication Room, Medication Carts, and Treatment cart are to be dated and	11/06/2024

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	manufacturer/supplier guidelines with respect to expiration dates for opened medications. Facility staff should record the date opened on the medication container..." 3.1-25(j)		labeled in accordance with professional principles. Whole facility audit completed in all three areas to ensure policy was being followed on 11/5/2024. Drug Storage Policy was reviewed and updated if necessary. Nursing personnel in serviced on policy and the storage and labeling of drugs and biologicals on 11/5/2024. DON/ADON in serviced on the policy, as well as discarding medications on 11/5/2024. Medication Room, Medication Carts, and Treatment Cart will be audited five days per week times four weeks, weekly times 4, and monthly x1. Any concerns will be addressed as discovered. If any patterns are identified at the monthly QAPI meeting an action plan will be written by the committee. Any written action plan will be monitored by the Admin and/or Designee monthly until resolved in substantial compliance is achieved.	
F 0800 SS=D Bldg. 00	483.60 Provided Diet Meets Needs of Each Resident Based on interview and record review, the facility failed to ensure a resident with a physician order for a carbohydrate controlled diet received the	F 0800	F800 Provided Diet Meets Needs of Each Resident **The facility ensures that each**	11/06/2024

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	correct diet for 1 of 1 resident reviewed for food. (Resident 35) Findings include: During an interview on 10/21/24 at 2:35 p.m., Resident 35 indicated he had been on a low carbohydrate (carb) diet while in the hospital. He was supposed to be on a low carb diet while in the facility but he had been getting meals with high carbs. For lunch today, he had ham salad on bread. He had gained weight since coming to the facility from eating too many carbs. During an interview on 10/22/24 at 2:37 p.m., Resident 35 indicated lunch today had been chicken and noodles but he was only able to eat the chicken because he was not supposed to have carbs. Resident 35's clinical record was reviewed on 10/22/24 at 2:43 p.m. The diagnosis included, but was not limited to, Type II Diabetes Mellitus. Physician orders, dated 9/1/24 through 9/30/24, for Resident 35 indicated "... regular diet, regular texture, regular/thin consistency ..." A review on 10/25/24 at 12:10 p.m., of the "Inpatient Hospital Discharge Orders", dated 9/27/24, for Resident 35 indicated, "... Discharge Diet: 9/27/24, Low-carb diet ..." During an interview on 10/24/24 at 1:56 p.m., the Administrator indicated she had not known Resident 35 was supposed to be on a carb controlled diet. During an interview on 10/24/24 at 2:01 p.m., the Administrator indicated the discharge orders from		**resident is provided with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident.** R35's meal card was immediately corrected to match his carb-controlled physician order on 10/24/2024. R35's diet order in PCC was immediately corrected on 10/24/2024 to match his carb-controlled physician order. Dietary Manager spoke with R35 on his preferences and likes/dislikes again on 10/24/2024. All residents have the potential to be affected by this finding. Dietary Staff and Nursing Managers educated on putting orders in accurately and effectively on 11/5/2024. Tray Card and Diet Order audit completed on whole facility to ensure accuracy by Dietary Manager on 11/6/2024. Diet Orders and Tray Cards audited weekly x3 months and upon any new admissions or changed diet orders by Dietary Manager. Any concerns will be	

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	the hospital had been for a carb controlled diet but the diet had been put in wrong at the facility when the resident admitted. On 10/25/24 at 12:09 p.m., the Administrator provided the facility's policy,"Diet Orders" undated, and indicated it was the policy currently being used by the facility. A review of the policy indicated, "... Guideline: Each resident will have a diet order prescribed by the physician ... Procedure: 3. Nursing confirms the the diet order is written utilizing standard terminology of the house diets before it is confirmed in the health record ..." 3.1-20(a)		addressed as discovered. If any patterns are identified at the monthly QAPI meeting an action plan will be written by the committee. Any written action plan will be monitored by the Admin and/or Designee monthly until resolved in substantial compliance is achieved.	