Faith Arvin

PRINTED: 11/14/2024 FORM APPROVED OMB NO. 0938-039

11/07/2024

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED	
		155532	B. WING		10/25/2024	
			STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIE	R		MILLER DR		
APERION	N CARE MONROE	:		MINGTON, IN 47401		
AI ENION CARE MICHICE		BEOOM	, , , , , , , , , , , , , , , , , , ,			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
F 0000						
Bldg. 00						
		a Recertification and State	F 0000	1 F000		
	Licensure Survey.			By submitting the enclosed		
	·			material, we are not admitting	to	
	Survey dates: Octo	ober 21, 22, 23, 24 and 25, 2024		the truth or accuracy of any		
				specific binding or allegations		
	Facility number: 0			reserve the right to contest the		
	Provider number:			finding or allegations as part of		
	AIM number: 100290620			any proceedings and submit t	hese	
				responses pursuant to our		
	Census Bed Type:			regulatory obligations. The fac	-	
	SNF/NF: 35			requests the Plan of Correctio	n be	
	Total: 35			considered our allegation of		
				compliance effective November	er	
	Census Payor Type	e:		6th, 2024 for the annual		
	Medicare: 2 Medicaid: 29			recertification and state licens	ure.	
	Other: 4			="" span="">		
	Total: 35					
	10tai. 55					
	These deficiencies	reflect State Findings cited in				
	accordance with 4	_				
	accordance with 4	10 11 (C 10.2-3.1)				
	Onality review cor	mpleted October 30, 2024.				
		inproted Science 30, 202 ii				
F 0623	483.15(c)(3)-(6)(8	3)				
SS=D	Notice Requirem					
Bldg. 00	Transfer/Dischar					
		v and record review, the facility	F 0623	F623 Notice Requirements Be	efore 11/06/2024	
	failed to ensure the	written notification required		Transfer/Discharge		
	for a transfer and c	lischarge was provided to the		The facility ensures the		
	resident and the re-	sident representative for 1 of 1		residents right to be notified	of	
	resident reviewed:	for hospitalization. (Resident		the requirements Before		
	33)			Transfer/Discharge and the		
				reasons for the move in writi	ing	
	Findings include:			and in a language and mann	er	
				they understand. The facility		
	Residents 33's clin	ical record was reviewed on		must send a copy of the noti	ce	
				l .		
LABORATOR	Y DIRECTOR'S OR PRO	OVIDER/SUPPLIER REPRESENTATIVE'S S	IGNATURE	TITLE	(X6) DATE	

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 disclosed days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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HFA

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155532	(X2) MULTIPLE (A. BUILDING B. WING	construction 00	(X3) DATE SURVEY COMPLETED 10/25/2024
	PROVIDER OR SUPPLIER		120 E	TADDRESS, CITY, STATE, ZIP COD MILLER DR MINGTON, IN 47401	
(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 CROSS-REFERENCED TO THE APPROVIDERICIENCY)	ON (X5) BE PRIATE COMPLETION DATE
		n. The diagnoses included, but dementia and fracture of the		to a representative of the of the State Long-Term Ca Ombudsman.	
	resident was sent to clinical record lacked notification of the T were provided to the representative. During an interview Administrator indict writing to the resided documented. On 10/25/24 at 12:0 provided the facility of Resident," dated the policy currently review of the policy written notification	the hospital on 9/30/24. The ed documentation the written transfer and Discharge forms are resident and the resident on 10/24/24 at 2:45 p.m., the ated the forms were sent in ent representative but was not on 10/28/12, and indicated it was being used by the facility. A or did not indicate sending the required for a transfer and ident and the resident		R33's clinical record was u with late entry on 10/24/202 the day of visit with family a hospital with SSD, where fawas given a copy of Transf Discharge Forms. All residents have the potent be affected by this finding. DON and SSD were in served 11/5/2024 on the important Transfer and Discharge for well as proper documentatic when mailing and/or giving residents and representative. Transfer and Discharge documentation as well as discharges, to be audited be five days per week times fow weeks, weekly times 4, and monthly x1. Any concerns ward addressed as discovered. If any patterns are identified monthly QAPI meeting an aplan will be written by the committee. Any written actiplan will be monitored by the Admin and/or Designee month was proper to the committee of the committee	24 from at amily er and witch and an at amily er and an at a a
F 0625 SS=D	483.15(d)(1)(2) Notice of Bed Hole	d Policy Before/Upon Trnsfr		until resolved in substantial compliance is achieved.	

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONS				URVEY
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLE	TED
		155532	B. W	ING		10/25/2	024
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER			120 E N	MILLER DR		
_	N CARE MONROE		BLOOMINGTON, IN 47401				
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
Bldg. 00	D 1 '4 '	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Б.О.	CO.5	5005 N. (; , , , , , , , , , , , , , , , , , ,		11/06/2024
		and record review, the facility	F 00	525	F625 Notice of Bed Hold Police	СУ	11/06/2024
		notification of the bed hold			Before/Upon Transfer		
		a resident who transferred to			The facility ensures the		
		ent representative for 1 of 1			residents right to be notified	OT	
		or hospitalization. (Resident			the Bed Hold Policy/Upon		
		or nospitalization. (Resident			Transfer. Before a nursing		
	33)				facility transfers a resident to hospital or the resident goes		
	Findings include:				therapeutic leave, the nursin		
	i manigs metade.				facility must provide written	9	
	Residents 33's clinic	cal record was reviewed on			information to the resident		
	10/22/24 at 2:02 p.m. The diagnoses included, but				and/or resident representative	۵,	
	were not limited to, dementia and fracture of the				and/or resident representative		
	left femur.				R33's clinical record was upda	ated	
	ion iomai.				with late entry on 10/24/2024		
	Resident 33's progre	ess notes indicated the			the day of visit with family at		
		the hospital on 9/30/24. The			hospital with SSD, where family	ilv	
		ed documentation the written			was given a copy of Bedhold	",	
		pecified the facility's bed hold			Forms.		
		I to the resident or the resident					
	representative.				All residents have the potentia	al to	
	•				be affected by this finding.		
	During an interview	on 10/24/24 at 2:45 p.m., the			, j		
	_	ated the forms were sent in			DON and SSD were in service	ed on	
	writing to the reside	ent representative but was not			11/5/2024 of the importance of		
	documented.				Bedhold Policy forms, as well		
					proper documentation when		
	On 10/25/24 at 12:0	9 p.m., the Administrator			mailing and/or giving to reside	ents	
	provided the facility	's policy,"Bed Hold and			and representatives.		
	Return to Facility,"	dated 11/28/12, and indicated					
	it was the policy cur	rrently being used by the			Bed Hold Policy documentation	on as	
	facility. A review of	f the policy indicated, "			well as discharges, to be audi	ted	
	Guidelines: The f	facility bed hold policy will be			by SSD five days per week tin	nes	
	given to the residen	t and/or resident			four weeks, weekly times 4, a	nd	
	representative as fol	llows At the time of a			monthly x1. Any concerns will	be	
	transfer from the fac	cility In cases of emergency			addressed as discovered.		
	transfer, notice [at t	ime of transfer] means that the					
	family or representa	tive are provided with written			If any patterns are identified a	t the	
	notification within 2	24 hours of the transfer"			monthly QAPI meeting an acti		

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		JILDING	00	COMPLETED 10/25/2024	
		155532	B. W	ING		10/25/	² 024
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
APERION	N CARE MONROE		120 E MILLER DR BLOOMINGTON, IN 47401				
(X4) ID	SUMMARY S	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	LSC IDENTIFYING INFORMATION	<u> </u>	TAG			DATE
	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 montruntil resolved in substantial compliance is achieved.	nly	
F 0641 SS=D Bldg. 00	483.20(g) Accuracy of Asses	ssments					
C	failed to ensure the Set (MDS) assessme reviewed for nutrition	and record review, the facility accuracy of the Minimum Data ent for a 2 of 2 residents on. Weight loss and IV ion were coded inaccurately.	F 00	541	F641 Accuracy of Assessment The facility ensures the resident rights of their assessments accurately reflecting the resident's state		11/06/2024
	Findings include: 1. Resident 7's clinic	cal record was reviewed on m. The diagnosis included, but			R7's MDS coding on weight w immediately corrected to incluthe correct and accurate weigh 10/25/2024.	de	
		Alzheimer's Disease.			R31's MDS coding on IV		
	A review of the We Resident 7 indicated	ights and Vitals Summary for I the following:			(intravenous) nutrition was immediately corrected to incluonly tube feeding as ordered of 10/25/2024.		
	-On 6/24/24, the res	sident weighed 116 pounds.					
	-On 7/8/24, the resid	dent weighed 110 pounds.			All residents have the potentia be affected by this finding.	ll to	
	-On 8/5/24, the resid	dent weighed 109 pounds.			IDT staff who do Admission M in serviced on the importance		
		dent weighed 105 pounds.			The Admission MDS Assessm and the accuracy of the		
	-On 10/11/24, the re	esident weighed 101 pounds.			information on 11/5/2024.		
	This was an assesse in 5 months.	d 12.93% severe weight loss			IDT staff and the Dietary Mana in serviced on the importance Accuracy of Assessments on	-	

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		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155532	(X2) MULTIPLE (A. BUILDING B. WING	construction 00	(X3) DATE SURVEY COMPLETED 10/25/2024	
NAME OF PROVIDER OR SUPPLIER APERION CARE MONROE		STREET ADDRESS, CITY, STATE, ZIP COD 120 E MILLER DR BLOOMINGTON, IN 47401				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR Resident 7's Annual 10/7/24, indicated the weight loss had not look back period. During an interview Assistant Director of Annual MDS assess	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION MDS assessment, dated the resident weighed 134 and been assessed during the Toon 10/25/24 at 10:15 a.m., the of Nursing indicated the sament, dated 10/7/24, for	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) 11/5/2024. MDS Assessments will be au five days per week times four weeks, weekly times 4, and monthly x1. Admission Assessments will be audited any admission or re-admission	dited	
	resident's weight los back period. 2. On 31's clinical record included, but were r injury, dysphagia (s respiratory failure. The Admission MD indicated the resident method of providing bloodstream through (medical device use people who cannot on	a coded incorrectly for the ss and weight during the look 10/22/24 at 1:43 p.m., Resident was reviewed. The diagnoses not limited to, traumatic brain wallowing difficulties), and S assessment, dated 9/13/24, not received Parenteral/IV (a g nutrition directly into the h a vein) and tube feedings d to provide nutrition to obtain nutrition by mouth, are afely, or need nutritional hile a resident.		Any concerns will be address as discovered. If any patterns are identified a monthly QAPI meeting an acreplan will be written by the committee. Any written action plan will be monitored by the Admin and/or Designee montuntil resolved in substantial compliance is achieved.	at the tion	
	the resident was received feeding). During an interview 9:40 a.m., the DON tube feedings and hadmitted. During an interview Nursing (ADON)/M 9:48 a.m., indicated	ers, dated 9/10/24, indicated eiving enteral feeding (tube with the DON on 10/25/24 at indicated the resident only had ad not had IV feedings since with the Assistant Director of IDS Coordinator on 10/25/24 at that the resident never had an the MDS assessment was on admission.				

	STATEMENT OF DEFICIENCIES X1) PROVIDER/S AND PLAN OF CORRECTION IDENTIFICATION 155532		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 10/25/2024	
	ROVIDER OR SUPPLIER		120 E I	ADDRESS, CITY, STATE, ZIP COD MILLER DR MINGTON, IN 47401		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE	
F 0761 SS=D	10/25/24 at 10:05 a. have a MDS assessifollowed the Reside (RAI) manual for co 3.1-31(d) 483.45(g)(h)(1)(2)					
Bldg. 00	Hash-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		F 0761	F761 Label/Store Drugs and Biologicals The facility ensures that all stored drugs and biological are labeled in accordance we currently accepted profession principles, and include the appropriate accessory and cautionary instructions, and expiration date when applicable. The opened, undated, tuberon PPD and Ozempic Injector Powas discarded and replaced of 10/24/2024 with a new vial art pen and was dated when open and was dated when open and was dated when open audits were completed a audits were conducted. No adverse actions were noted withis finding. All medications in the Medical Room, Medication Carts, and Treatment cart are to be date	with onal If the culin cen con concend cened. all to concend cened. as with cution cution concend cened.	

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155532	(X2) MULTIPLE C A. BUILDING B. WING	OO	(X3) DATE SURVEY COMPLETED 10/25/2024
	PROVIDER OR SUPPLIER		120 E	ADDRESS, CITY, STATE, ZIP COD MILLER DR MINGTON, IN 47401	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	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
	expiration dates for	ier guidelines with respect to opened medications. Facility the date opened on the er"		labeled in accordance with professional principles. Whole facility audit completed in all the areas to ensure policy was be followed on 11/5/2024. Drug Storage Policy was reviewed.	hree eing ewed
				and updated if necessary. Nur personnel in serviced on police and the storage and labeling of drugs and biologicals on 11/5/2024.	ry of
				DON/ADON in serviced on the policy, as well as discarding medications on 11/5/2024.	9
				Medication Room, Medication Carts, and Treatment Cart wil audited five days per week tin four weeks, weekly times 4, a monthly x1. Any concerns will addressed as discovered.	l be nes nd
				If any patterns are identified a monthly QAPI meeting an actiplan will be written by the committee. Any written action plan will be monitored by the Admin and/or Designee montluntil resolved in substantial compliance is achieved.	ion
F 0800 SS=D Bldg. 00	483.60 Provided Diet Mee	ets Needs of Each Resident			
	failed to ensure a re	and record review, the facility sident with a physician order controlled diet received the	F 0800	F800 Provided Diet Meets Ne of Each Resident The facility ensures that eac	11/00/2021

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AND PLAN OF CORRECTION IDEN'		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155532	(X2) MULTIPLE (A. BUILDING B. WING	CONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 10/25/2024		
NAME OF P	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP COD				
APERION CARE MONROE		120 E MILLER DR BLOOMINGTON, IN 47401					
(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 APPROPR			
TAG		LISC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE		
		1 resident reviewed for food.		resident is provided with a			
	(Resident 35) Findings include:			nourishing, palatable, well-balanced diet that mee	te		
				his or her daily nutritional a	nd		
	During an interview	on 10/21/24 at 2:35 p.m.,		special dietary needs, takin into consideration the	9		
	_	ed he had been on a low		preferences of each resider	nt.		
	carbohydrate (carb)	diet while in the hospital. He					
	was supposed to be	on a low carb diet while in the		R35's meal card was immed	ately		
	•	een getting meals with high		corrected to match his			
		lay, he had ham salad on		carb-controlled physician ord	er on		
	bread. He had gained weight since coming to the			10/24/2024.			
	facility from eating too many carbs.						
	During an interview on 10/22/24 at 2:37 p.m.,			R35's diet order in PCC was			
	_	ed lunch today had been		immediately corrected on 10/24/2024 to match his			
		s but he was only able to eat		carb-controlled physician ord	or .		
		the was not supposed to have		Carb-controlled physician ord	Ci.		
	carbs.	The state of the s		Dietary Manager spoke with	R35		
				on his preferences and			
	Resident 35's clinic	al record was reviewed on		likes/dislikes again on 10/24/	2024.		
	-	n. The diagnosis included, but					
	was not limited to,	Гуре II Diabetes Mellitus.		All residents have the potent	al to		
	Di ''	1.0/1/04/1 1.0/20/24 2		be affected by this finding.			
	•	ated 9/1/24 through 9/30/24, for		Dietem Cheff I Nove-in			
	texture, regular/thin	ed " regular diet, regular		Dietary Staff and Nursing Managers educated on puttir	ng l		
	cature, regular/tilli	consistency		orders in accurately and effe	·		
	A review on 10/25/	24 at 12:10 p.m., of the		on 11/5/2024.	ouvory		
		Discharge Orders", dated					
		nt 35 indicated, " Discharge		Tray Card and Diet Order au	dit		
	Diet: 9/27/24, Low-	carb diet"		completed on whole facility to			
				ensure accuracy by Dietary			
	-	on 10/24/24 at 1:56 p.m., the		Manager on 11/6/2024.			
		ated she had not known					
		pposed to be on a carb		Diet Orders and Tray Cards			
	controlled diet.			audited weekly x3 months ar	l l		
	During an interview	on 10/24/24 at 2:01 p.m., the		upon any new admissions or changed diet orders by Dieta			
	_	ated the discharge orders from		Manager. Any concerns will I	-		
		area are arbentarge oracis moni	1	I Manager. Any concerns will i	~		

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155532	· /	JILDING	INSTRUCTION 00	(X3) DATE COMPL 10/25	ETED
NAME OF PROVIDER OR SUPPLIER APERION CARE MONROE				120 E M	ADDRESS, CITY, STATE, ZIP COD MILLER DR MINGTON, IN 47401		
(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)	TE	(X5) COMPLETION DATE
	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 diet order is written utilizing standard terminology of the house diets before it is confirmed in the health record"				addressed as discovered. If any patterns are identified at monthly QAPI meeting an actiplan will be written by the committee. Any written action plan will be monitored by the Admin and/or Designee month until resolved in substantial compliance is achieved.	on	

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