	T OF HEALTH AND HUN R MEDICARE & MEDIC						TED: 12/31/2024 RM APPROVED B NO. 0938-039
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		A. BUILDING			ETED
		155532	B. W	NG		11/21/	2024
NAME OF PROVIDER OR SUPPLIER APERION CARE MONROE				STREET ADDRESS, CITY, STATE, ZIP COD 120 E MILLER DR BLOOMINGTON, IN 47401			
OVA ID	CLD O () DV	CT A TEN ANYTH OF DEFICIENCIE			T		OV.
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	``	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		CROSS-REFERENCED TO THE APPRI		ΓΕ	DATE
E 0000	REGULATORT OR	LESC IDENTIFTING INFORMATION		TAG			DATE
Bldg	conducted by the In accordance with 42 Survey Date: 11/21 Facility Number: 0 Provider Number:	/24 00460 155532	E 00	000	1 E000 By submitting the enclosed material, we are not admitting the truth or accuracy of any specific binding or allegations. reserve the right to contest the finding or allegations as part or any proceedings and submit the	We e f	
	Care Monroe was for Emergency Prepare Medicare and Medi- and Suppliers, 42 C	Preparedness survey, Aperion bund not in compliance with dness Requirements for caid Participating Providers			responses pursuant to our regulatory obligations. The fac requests the Plan of Correction considered our allegation of compliance effective December 2nd, 2024 for the Annual Life Safety Recertification and Stat Licensure Emergency Preparedness Survey.	n be er	

Based on record review and interview, the facility E 0004 12/02/2024 failed to review and update the Emergency E004 Preparedness Plan (EPP) at least annually in The facility develops and accordance with 42 CFR 483.73(a). This deficient implements emergency practice could affect all occupants. preparedness plans and they are evaluated and updated at least Findings include: annually. Disaster plan has been reviewed Based on records review and interview with the and updated on 11/25/2024 with Administrator and Maintenance Director (MD) on the date of review documented. 11/21/24 between 8:30 a.m. and 1:00 p.m., the EEP Cover page with updated and

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

lacked a cover page, and no date could be found

to show the EPP was reviewed and updated within

had a census of 36 at the time of this visit.

Quality Review completed on 11/22/24

403.748(a), 416.54(a), 418.113(a), 441.1

Develop EP Plan, Review and Update

E 0004

SS=F

Bldg. --

Annually

(X6) DATE

reviewed date added to EOP

TITLE

binder.

Faith Arvin **HFA** 12/23/2024

Any defiencystatement 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 disclo 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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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE			(X3) DATE S	SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING			COMPL	ETED
		155532				11/21/	
					_		-
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
ADEDIOA	LOADE MONDOE				MILLER DR		
APERION	N CARE MONROE			BLOOM	IINGTON, IN 47401		
(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
	the last year. Based	on an interview during			All residents have the potentia	l to	
	records review, the	Administrator stated the EEP			be affected by this finding.		
	was reviewed recen	tly but during the survey no			The maintenance director rece	eived	
	documentation was	provided indicating the EPP			in servicing education on		
	was updated within	the last year. This finding was			requirements for the disaster p	olan	
	acknowledged by th	e Administrator and MD at			to be kept current and reviewe		
	the time of records i	review and again at the exit			a minimum annually.		
	conference.				All facility staff received in		
					servicing education on 11/26/2	2024	
					on the EOP binder, requireme		
				location and purpose.			
				The administrator and/or desig	jnee		
				will monitor the emergency			
				preparedness plans including	but		
					not limited to the disaster plan		
					monthly x three months. The		
					findings of the monitoring will b	ре	
					reported to QAPI committee		
					monthly by the maintenance		
					director or his designee.		
					-		
E 0013	403.748(b), 416.54	4(b), 418.113(b), 441.1					
SS=F	Development of E	P Policies and Procedures					
Bldg							
	Based on record rev	riew and interview, the facility	E 00)13	E013		12/02/2024
		update the Emergency			The facility develops and		
	•	(EPP) Policies and Procedures			implements emergency		
	at least annually in a	accordance with 42 CFR			preparedness policies and		
	483.73(a). This defi	cient practice could affect all			procedures.		
	occupants.				Disaster plan has been review	ed	
					and updated on 11/25/2024 wi	th	
	Findings include:				the date of review documented	d.	
					Cover page with updated and		
	Based on records re	view and interview with the			reviewed date added to EOP		
	Administrator and M	Maintenance Director (MD) on			binder.		
	11/21/24 between 8	:30 a.m. and 1:00 p.m., the EEP			All residents have the potentia	l to	
	lacked a cover page	, and no date could be found			be affected by this finding.		
	to show the EPP wa	s reviewed and updated within			The maintenance director rece	eived	
	the last year. Based	on an interview during			in servicing education on		
	records review, the	Administrator stated the EEP's			requirements for the disaster p	olan	

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CENTERS FO	R MEDICARE & MEDIC	AID SERVICES			OM	B NO. 0938-039
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155532	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 11/21/2024	
	PROVIDER OR SUPPLIER	t	120 E N	ADDRESS, CITY, STATE, ZIP COD MILLER DR MINGTON, IN 47401		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	but during the surve provided indicating Procedures were up This finding was ac Administrator and I	dures were reviewed recently ey no documentation was the EPP Policies and dated within the last year. eknowledged by the MD at the time of records the exit conference.		to be kept current and reviewed a minimum annually. This inclupolicies and procedures. The administrator and/or designial monitor the emergency preparedness monthly x three months. The findings of the monitoring will be reported to QAPI committee monthly by the maintenance director or his designee.	udes gnee	
E 0018 SS=F Bldg	Procedures for Tr Based on record rev failed to ensure eme	6.54(b)(1), 418.113(b)(acking of Staff and Patients view and interview, the facility ergency preparedness policies	E 0018	E018 The facility develops and		12/02/2024
	location of on-duty in the LTC facility! emergency. If on-du- residents are reloca LTC facility must of location of the rece in accordance with deficient practice of	ude a system to track the staff and sheltered residents is care during and after an auty staff and sheltered ited during the emergency, the document the specific name and aiving facility or other location 42 CFR 483.73(b) (2). This could affect all occupants.		implements polices and procedures that include a syst to track the location of on-duty staff and sheltered residents in LTC facility's care during and an emergency. Disaster plan has been review and updated on 11/25/2024 w the date of review documented Cover page with updated and	n the after red ith	
	Administrator and I 11/21/24 between 8 and procedure that location of sheltered care during and after but the policy did not the location for on-	eview and interview with the Maintenance Director (MD) on 1:30 a.m. and 1:00 p.m., a policy includes a system to track the d residents in the LTC facility's er an emergency was provided, ot provide a system to track duty staff. This finding was ne Administrator and MD at		reviewed date added to EOP binder. All residents have the potential be affected by this finding. The maintenance director recein servicing education on requirements for the disaster put to be kept current and reviewed a minimum annually. This inclupolicies and procedures. The administrator and/or designation and/or designation in the policies.	eived blan ed at udes	

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conference.

the time of records review and again at the exit

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will monitor the emergency

preparedness policies and

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155532		(X2) MULTIPLE (A. BUILDING B. WING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED 11/21/2024		
APERIO	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 120 E MILLER DR BLOOMINGTON, 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)	(X5) COMPLETION DATE	
				procedures (tracking) monthly three months. The findings of monitoring will be reported to QAPI committee monthly by the maintenance director or his designee.	the	
E 0024 SS=F Bldg	Policies/Procedure Based on record rev failed to ensure eme	6.54(b)(5), 418.113(b)(es-Volunteers and Staffing riew and interview, the facility ergency preparedness plan use of volunteers in an	E 0024	E024 The facility develops and implements policies and	12/02/2024	
	including the proces State or Federally d professionals to add emergency in accor	emergency staffing strategies, and role for integration of esignated health care ress surge needs during an dance with 42 CFR 483.475(b) ractice could affect all		procedures that include the us volunteers in an emergency of other emergency staffing strategies. Disaster plan has been review and updated on 11/25/2024 with edate of review documenteers.	red ith	
	Findings include:	· · · · · · · · · · · · · · · · · · ·		Cover page with updated and reviewed date added to EOP binder.		
	Administrator and M 11/21/24 between 8 provided did not adan emergency. Base records review, the facility did not usua unaware of a writter were used or if voluguidelines would be the use or non-use of	view and interview with the Maintenance Director (MD) on :30 a.m. and 1:00 p.m., the plan dress the use of volunteers in do on interview at the time of Administrator stated the lly use volunteers but was a policy stating no volunteers inteers were used, what it in place and did not address of volunteers in an emergency.		All residents have the potential be affected by this finding. The maintenance director recein servicing education on requirements for the disaster probability to be kept current and reviewed a minimum annually. This inclupolicies and procedures. The maintenance director recein servicing education on the volunteer policy. The administrator and/or designable will monitor the approach.	eived plan ed at udes eived	
	This finding was ac Administrator and M review and again at	MD at the time of records		will monitor the emergency preparedness policies and procedures (volunteers) month three months. The findings of monitoring will be reported to	-	

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED	
		155532	B. WING 11/21/2024				
NAME OF PROVIDER OR SUPPLIER APERION CARE MONROE				120 E N	ADDRESS, CITY, STATE, ZIP COD MILLER DR MINGTON, IN 47401		
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE OT TO THE APPROPRIA TAG DEFICIENCY)		ιΤΕ	(X5) COMPLETION DATE
					QAPI committee monthly by the maintenance director or his designee.		
E 0026 SS=F Bldg	1 ' ' ' '	6.54(b)(6), 418.113(b)(niver Declared by Secretary					
	failed to ensure the (EEP) include the re waiver declared by with section 1135 o care and treatment a identified by emergaccordance with 42 deficient practice compared in the section of	Emergency Preparedness Plan ole of the LTC facility under a the Secretary, in accordance of the Act, in the provision of the analternate care site ency management officials in CFR 483.73(b) (8). This ould affect all occupants. View and interview with the Maintenance Director (MD) on the color of the LTC facility ared by the Secretary, in the stion 1135 of the Act was not to the Treview and again at the exit	E 00	026	The facility develops and implements policies and procedures that include the ro the LTC facility under a waiver declared by the secretary, in accordance with section 1135 the act. Disaster plan has been review and updated on 11/25/2024 w the date of review documented. Cover page with updated and reviewed date added to EOP binder. 1135 waiver placed in EOP binder. 1135 waiver placed in EOP binder. 1136 waiver placed in EOP binder. The maintenance director recein servicing education on requirements for the disaster place to be kept current and reviewed a minimum annually. This inclupolicies and procedures. The maintenance director recein servicing education on the factor in servicing education on the factor. The administrator and/or designative. The administrator and/or designative monitor the emergency preparedness policies and procedures (volunteers) month three months. The findings of monitoring will be reported to QAPI committee monthly by the second committee mont	of ved with d. nder. al to eived plan ed at udes eived 1135 gnee hly x the	12/02/2024

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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			COMPL	ETED
		155532	B. WING			11/21/2024	
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 120 E MILLER DR BLOOMINGTON, IN 47401				
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	BROWING BLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	rc	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	16	DATE
E 0029 SS=F Bldg	Development of C	4(c), 418.113(c), 441.1 ommunication Plan iew and interview, the failed	E 00)29	maintenance director or his designee.		12/02/2024
	to review and update Preparedness Plan's least annually in acc 483.73(a). This definoccupants. Findings include: Based on records read Administrator and Marked a cover page to show the EPP's Creviewed and update Based on an interview Administrator stated was reviewed recent documentation was Communications Playear. This finding was	e the Emergency (EPP) Communication Plan at cordance with 42 CFR cient practice could affect all view and interview with the Maintenance Director (MD) on 30 a.m. and 1:00 p.m., the EEP , and no date could be found communication Plan was ed within the last year. ew during records review, the If the EEP Communication Plan thy but during the survey no provided indicating the an was updated within the last was acknowledged by the MD at the time of records			The facility develops and implements emergency preparedness communication plans that complies with the federal, state, and local laws. Disaster plan has been review and updated on 11/25/2024 withe date of review documented Cover page with updated and reviewed date added to EOP binder. All residents have the potential be affected by this finding. The maintenance director recein servicing education on requirements for the disaster pto be kept current and reviewed a minimum annually. All facility staff received in servicing education on 11/26/2 on the EOP binder, requirement location and purpose. The administrator and/or designification will monitor the emergency preparedness plans including anot limited to the disaster plan monthly x three months. The findings of the monitoring will be reported to QAPI committee monthly by the maintenance director or his designee.	I to Dived Dian d at 2024 nts, gnee	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155532			JILDING	NSTRUCTION	(X3) DATE COMPL 11/21/	ETED	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 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 APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
E 0036 SS=F Bldg	403.748(d), 416.5 EP Training and T	4(d), 418.113(d), 441.1 esting					
E 0041 SS=F	failed to review and Preparedness Plan's Plan at least annuall 483.73(a). This defi occupants. Findings include: Based on records re Administrator and M 11/21/24 between 8 lacked a cover page to show the EPP's T reviewed and updat on an interview dur. Administrator stated Testing Plan was re survey no documen finding was acknow and MD at the time the exit conference.	view and interview, the facility updated the Emergency (EPP) Training and Testing by in accordance with 42 CFR cient practice could affect all view and interview with the Maintenance Director (MD) on 130 a.m. and 1:00 p.m., the EEP, and no date could be found fraining and Testing Plan was ed within the last year. Based ing records review, the different the EEP Training and viewed recently but during the tation was provided. This reledged by the Administrator of records review and again at	E 00	036	E036 The facility develops and maintains an emergency preparedness training and test program that is based on the emergency plan at least annual the training and testing program has been reviewed, dated, and updated if necessary on 11/25/2024. All residents have the potential be affected by this finding. The maintenance director recein servicing education on requirements for the disaster put to be kept current and reviewed a minimum annually. All facility staff received in servicing education on 11/26/2 on the EOP binder, requiremed location and purpose. The administrator and/or designial monitor that the training are testing program has been reviewed, dated, and updated least annually, monthly x three months. The findings of the monitoring will be reported to QAPI committee monthly by the maintenance director or his designee.	ally. am d If to eived clan ed at 2024 ents, gnee end at	12/02/2024
Bldg		riew and interview, the facility the emergency power system	E 00	041	E041 The facility ensures the		12/23/2024

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155532		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 11/21/2024			
	ROVIDER OR SUPPLIER	<u>.</u>	STREET ADDRESS, CITY, STATE, ZIP COD 120 E MILLER DR BLOOMINGTON, IN 47401				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG DEFICIENCY)		ΓE	(X5) COMPLETION DATE	
	inspection, testing, found in the Health 110, and Life Safety CFR 483.73(e)(2). affect all occupants Findings include: Based on records re Maintenance Direct 11/21/24 between 8 facility provided do emergency generate documentation of a This was confirmed was new to the facil requirement. This finding was records and the safety of the	and maintenance requirements Care Facilities Code, NFPA by Code in accordance with 42 This deficient practice could aview and observation with the for (MD) and Administrator on 30 a.m. and 1:00 p.m., the cumentation for testing of the for, however, could not provide three year 4 hour load test. by the MD, who stated he lity and was unaware of the viewed with the MD and te time of discovery and again			emergency power system inspection, testing, and maintenance requirements are completed. All residents have the potential be affected by this finding. 4 HR/36 month generator run be completed on 12/23/2024. Work from Evapar approved from preventative maint work on machine. Generator log documentation be filed with generator logs an attached. The maintenance director recein servicing education on emergency power system inspections, testing, and maintenance requirements and required 4 HR/36 month generator. The administrator and/or designill monitor the emergency posystem logs monthly x three months. The findings of the monitoring will be reported to QAPI committee monthly by the maintenance director or his designee.	I to will om will d dived	
K 0000							
Bldg. 01	Licensure Survey w	Recertification and State vas conducted by the Indiana th in accordance with 42 CFR	K 00	000	1 E000 By submitting the enclosed material, we are not admitting the truth or accuracy of any specific binding or allegations. reserve the right to contest the finding or allegations as part or	We	

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155532		A. BUILDING B. WING	01	COMPLETED 11/21/2024			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 120 E MILLER DR BLOOMINGTON, 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)	(X5) COMPLETION DATE		
	Monroe was found a Requirements for Pa Medicare/Medicaid, Life Safety from Fin National Fire Protect Life Safety Code (L Health Care Occupa This one story facilit Type II (111) constr sprinklered. The fact with hard wired smoth and spaces open to to operated smoke alar rooms. The facility is census of 36 at the t All areas where resi were sprinklered and services were sprink sheds used for facility Quality Review con	290620 Code survey, Aperion Care not in compliance with articipation in , 42 CFR Subpart 483.90(a), re and the 2012 edition of the stion Association (NFPA) 101, SC), Chapter 19, Existing ancies and 410 IAC 16.2. Ty was determined to be of ruction and was fully illity has a fire alarm system obke detectors in the corridors the corridors, plus battery rms in all resident sleeping has a capacity of 38 and had a ime of this survey. In the control of the corridors are alarm system of the corridors, plus battery rms in all resident sleeping has a capacity of 38 and had a ime of this survey. In the corridors are alarm system of the corridors are alarm system of the corridors, plus battery rms in all resident sleeping that a capacity of 38 and had a ime of this survey.		any proceedings and submit the responses pursuant to our regulatory obligations. The fact requests the Plan of Correction considered our allegation of compliance effective December 2nd, 2024 for the Annual Life Safety Recertification and Statilicensure Emergency Preparedness Survey.	cility n be er		
K 0211 SS=E Bldg. 01	NFPA 101 Means of Egress -						
	failed to ensure 1 of continuously mainta or impediments to fi fire or other emerge	on and interview, the facility A means of egress was ained free of all obstructions all instant use in the case of ncy. This deficient practice residents, staff and visitors if facility.	K 0211	K211 The facility ensures aisles, passageways, corridors, exit discharges, exit locations, and accesses are all free of obstructions to full use in case emergency. All affected obstructed areas v	e of		

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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 01 COMPLETED B. WING 11/21/2024 155532 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 120 E MILLER DR APERION CARE MONROE **BLOOMINGTON. IN 47401** (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE Findings include: immediately resolved. All residents have the potential to Based on observations and interviews with the be affected by this finding. Maintenance Director (MD) and Administrator The maintenance director received during a tour of the facility on 11/21/24 between in servicing education on 10:15 a.m. and 11:30 a.m., the exit corridor across 11/21/2024 on corridor from the nurses' station leading to the side exit obstructions. contained 15 large boxes. This condition was All facility staff received in observed at 8:15 a.m. when the surveyor entered servicing education on 11/21/2024 the facility. The condition was present throughout in regard to corridor obstructions, the survey and at the exit. The MD stated that the and boxes and items being left at delivery material had not been sorted and put the doors. away. The Administrator stated that the facility The maintenance director and/or struggles with a lack of storage space. designee will monitor the corridors daily x 4 weeks, and weekly x2 This finding was reviewed with the MD and months. The findings of the Administrator at the time of discovery and again monitoring will be reported to at the exit conference. QAPI committee monthly by the maintenance director or his 3.1-19(b) designee. K 0222 **NFPA 101** SS=E **Egress Doors** Bldg. 01 Based on observation and interview, the facility K 0222 K222 12/02/2024 failed to ensure the means of egress through the The facility ensures the means of Main Entrance exit was readily accessible for egress through the main residents without a clinical diagnosis requiring entrance/exit was readily specialized security measures. Doors within a accessible. required means of egress shall not be equipped All residents have the potential to with a latch or lock that requires the use of a tool be affected by this finding. or key from the egress side unless otherwise All main entrance/exit's permitted by LSC 19.2.2.2.4. Door-locking immediately made readily arrangements shall be permitted in accordance accessible with codes posted by with 19.2.2.2.5.2. This deficient practice could MD on 11/21/2024. affect over 15, staff and visitors if needing to exit The maintenance director received the facility. in servicing education on 11/21/2024 on door codes, at a Findings include: legible font and size and updating monthly or as needed and/or

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 01 COMPLETED 155532 B. WING 11/21/2024 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 120 E MILLER DR BLOOMINGTON, IN 47401 APERION CARE MONROE

APERIO	N CARE MONROE	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		
14,0000	Based on observations and interviews with the Maintenance Director (MD) and Administrator during a tour of the facility on 11/21/24 between 10:15 a.m. and 11:30 a.m., the (1) Main Entrance exit door, (2)side exit door, and (3) rear exit door each marked as a facility exit, was magnetically locked and could be opened by entering a four digit code but the code was not posted at the exit. This finding was reviewed with the MD and Administrator at the time of discovery and again at the exit conference. 3.1-19(b)		changed. The maintenance director and/or designee will monitor the entrance/exit's daily x 4 weeks, and weekly x2 months. The findings of the monitoring will be reported to QAPI committee monthly by the maintenance director or his designee.			
K 0300 SS=F Bldg. 01	NFPA 101 Protection - Other					
	Based on record review, interview, and observation, the facility failed to ensure documentation for the preventative maintenance of all battery-operated smoke alarms in resident rooms was complete. NFPA 101 in 4.6.12.3 states existing life safety features obvious to the public, if not required by the Code, shall be maintained. NFPA 72, 29.10 Maintenance and Tests. Fire-warning equipment shall be maintained and tested in accordance with the manufacturer's published instructions and per the requirements of Chapter 14. NFPA 72, 14.2.1.1.1 Inspection, testing, and maintenance programs shall satisfy the requirements of this Code and conform to the equipment manufacturer's published instructions. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on records review and observation with the Maintenance Director (MD) and Administrator on 11/21/24 between 8:30 a.m. and 1:00 p.m., no	K 0300	K300 The facility ensures documentation for the preventative maintenance of all battery-operated smoke alarms in resident rooms is complete. All residents have the potential to be affected by this finding. All battery-operated smoke alarms were tested on 11/22/2024. All documentation attached and findings included. The maintenance director received in servicing education on 11/22/2024 on battery operated smoke alarms and documentation. Not limited to cleaning logs, install dates, and testing logs. The maintenance director and/or designee will monitor the battery-operated smoke alarms weekly x4 weeks and monthly x2 months. The findings of the	12/02/2024		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155532		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 11/21/2024			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 120 E MILLER DR BLOOMINGTON, IN 47401				
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION		ID PROVIDER'S PLAN OF CORRECTI PREFIX (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)		(X5) COMPLETION DATE		
	maintenance of resists smoke alarms was a Furthermore, the do and cleaning of the review. No docume manufacture and instantery-operated sm for review. The doctemplate only provibattery-operated sm but the data was blatthe time of review, stated no other doct During the tour batt were observed in th This finding was rev	cumentation reflecting testing appliances was available for intation indicating the stall dates of the oke detectors was available umentation provided was a ding an itemized list of the oke detectors in the facility, ink. Based on interviews at the Maintenance Director umentation was available. The properties are resident sleeping rooms. Wiewed with the MD and a time of discovery and again		monitoring will be reported to QAPI committee monthly by the maintenance director or his designee.	ne		
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas	- Enclosure					
_	failed to ensure the hazardous rooms we self-closing device automatically close This deficient practification. Findings include: Based on observation Maintenance Direct during a tour of the 10:15 a.m. and 11:3 following hazardous.	on and interview, the facility corridor doors to 2 of over 4 ere provided with a which would cause the door to and latch into the door frame. Ice could affect 4 staff. ons and interviews with the or (MD) and Administrator facility on 11/21/24 between 0 a.m., the corridor doors to the stareas did not meet the otection of a hazardous area:	K 0321	K321 The facility ensures corridor of have a self-closing device that would cause the door to automatically close and latch the door frame. All residents have the potential be affected by this finding. All affected doors were immediately fixed to be self-closing as necessary. (Kitchen and Nursing Supply.) Trash Receptacles immediated removed, and oxygen cylinde were placed in the proper store.	t into al to ely rs		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155532		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 11/21/2024		
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 120 E MILLER DR BLOOMINGTON, IN 47401			
(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)	DATE	
K 0346 SS=C Bldg. 01	self-close and latch. trash receptacles. b) The Nurses Supp latch. The aforemen 20 oxygen cylinders Based on interview Maintenance Direct hazardous storage a rooms did not self-c This finding was rev Administrator at the at the exit conference 3.1-19(b) NFPA 101 Fire Alarm System	n - Out of Service		The maintenance director rec in servicing education on 11/21/2024 on doors closing a latching. The maintenance director and designee will monitor the corr doors weekly x4 weeks and monthly x2 months to ensure there are no findings and are self-closing and functioning correctly. The findings of the monitoring will be reported to QAPI committee monthly by the maintenance director or his designee.	and d/or idor	
	failed to provide a completing the ISDH Gateway link at Israel of the IsDH Gateway completing the IsDH Gateway completing the Ischeduler of the provided and failed to Indiana Department Gateway link at http://primary.method.or.link.	riew and interview, the facility complete 1 of 1 written policy residents indicating lowed in the event the fire be placed out of service for in a twenty four hour period in C, Section 9.6.1.6. This fects all occupants. The section of the event the fire be placed out of service for in a twenty four hour period in C, Section 9.6.1.6. This fects all occupants. The section of the event the fire include contacting the contacting the secondary method when its nonoperational by dent Reporting form and ents@isdh.in.gov. Based on	K 0346	K346 The facility ensures to provide complete written policy indical procedures to be followed in the event the fire alarm system of the placed out of service. Fire Alarm System policy has been reviewed and updated. All residents have the potential be affected by this finding. The maintenance director recein servicing education on the land sprinkler policies. The administrator and/or desimilar monitor the emergency preparedness policies and procedures (fire alarm system monthly x three months. The findings of the monitoring will reported to QAPI committee monthly by the maintenance	ting he ust al to eived fire gnee	

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA			X3) DATE SURVEY		
		IDENTIFICATION NUMBER	A. BUILDING <u>01</u>			COMPLETED	
		155532	B. WIN	IG		11/21/	/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	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	F	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
K 0354	interview during the Maintenance Direct watch documentation the Indiana Departn	e record review, the for acknowledged the fire on provided stated to contact ment of Health at a phone the ISDH Gateway link or at			director or his designee.		
SS=C Bldg. 01	Based on record reversal failed to provide 1 of the event the automorplaced out-of-service 24-hour period in an 9.7.5. LSC 9.7.6 recorded procedures comply the Standard for the Maintenance of Was Systems. NFPA 25 procedures that the follow. A.15.5.2 (4) consist of trained per patrol the affected and extinguishers and the fire department consider. During the should not only be 1 sure that the other fibuilding such as egain are available and further deficient practice confacility. Findings include:	view and interview, the facility of 1 correct written policies in atic sprinkler system has to be the for 10 hours or more in a coordance with LSC, Section quires sprinkler impairment with NFPA 25, 2011 Edition, and ter-Based Fire Protection, 15.5.2 requires nine impairment coordinator shall to (b) states a fire watch should ersonnel who continuously area. Ready access to fire the ability to promptly notify are important items to be patrol of the area, the person tooking for fire, but making the protection features of the ress routes and alarm systems notioning properly. This build affect all occupants in the	K 03	54	K354 The facility ensures to provide complete written policy indicat procedures to be followed in the event the sprinkler system mube placed out of service. Sprinkler alarm system policy been reviewed and updated All residents have the potential be affected by this finding. The maintenance director recein servicing education on the find sprinkler policies. The administrator and/or designil monitor the emergency preparedness policies and procedures (sprinkler system) monthly x three months. The findings of the monitoring will be reported to QAPI committee monthly by the maintenance director or his designee.	ing ne st has al to eived iire gnee	12/02/2024
	Based on observations and interviews with the Maintenance Director (MD) and Administrator on						

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155532	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 11/21/2024		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 120 E MILLER DR BLOOMINGTON, 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)	(X5) COMPLETION DATE		
K 0355 SS=E Bldg. 01	watch plan failed to Indiana Department Gateway link at http primary method or lethe ISDH Gateway completing the Incider-mailing it to incide interview during the Maintenance Direct watch documentation the Indiana Department number, and not viathe e-mail address list of the e-mail address list of the Indiana Department of the e-mail address list of	or acknowledged the fire on provided stated to contact nent of Health at a phone the ISDH Gateway link or at isted above.	K 0355	K355 The facility ensures portable fextinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10 standards. Effected portable fire extinguisimmediately unblocked by the obstructed item on 11/21/2024. All residents have the potentiable affected by this finding. The maintenance director recin servicing education on 11/21/2024 on fire extinguished obstructions, and double check these accesses. All facility staff received in servicing education on 11/21/in regard to keeping the fire extinguisher's clear in all area	h sher e 4. al to eived er cking		

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CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 01 COMPLETED 155532 B. WING 11/21/2024

STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 120 E MILLER DR

APERION CARE MONROE			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	
K 0363 SS=E	impede its release from the wall. This finding was reviewed with the MD and Administrator at the time of discovery and again at the exit conference. 3.1-19(b) NFPA 101 Corridor - Doors		the facility and being sure they are not obstructed. The maintenance director and/or designee will monitor the fire extinguishers daily x 4 weeks, and weekly x2 months. The findings of the monitoring will be reported to QAPI committee monthly by the maintenance director or his designee.		
Bldg. 01	Based on observation and interview, the facility failed to ensure all corridor doors had no impediment to closing and latching into the door frame and would resist the passage of smoke. This deficient practice could affect 6 staff and 15 residents. Findings include: Based on observations and interviews with the Maintenance Director (MD) and Administrator during a tour of the facility on 11/21/24 between 10:15 a.m. and 11:30 a.m., the following corridor doors failed to latch positively into their respective door frames: a) Pantry Door near the Kitchen b) Double door set near resident room #4 failed to completely close, this door was also obstructed from closing with a utility cart. This finding was reviewed with the MD and Administrator at the time of discovery and again at the exit conference. 3.1-19(b)	K 0363	K363 The facility ensures all corridor doors have no impediment to closing and latching into the door frame to resist the passage of smoke. All residents have the potential to be affected by this finding. All affected doors were immediately fixed to be self-closing and latching as necessary. The maintenance director received in servicing education on 11/21/2024 on doors closing and latching Utility cart moved from obstructed door. All facility staff received in servicing education on 11/21/2024 in regard to corridor obstructions, and boxes and items being left at the doors. The maintenance director and/or designee will monitor the corridor doors weekly x4 weeks and monthly x2 months to ensure	12/02/2024	

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>01</u>		01	COMPLETED	
155		155532	B. WING			11/21/2024	
<u> </u>				STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	ROVIDER OR SUPPLIER	L	120 E MILLER DR				
APERION CARE MONROE					MINGTON, IN 47401		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX				COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					there are no findings and are		
					self-closing and functioning		
					correctly. The findings of the	•	
					monitoring will be reported to		
					QAPI committee monthly by the		
					maintenance director or his		
					designee.		
K 0364	NFPA 101						
SS=E	Corridor - Opening	ne					
Bldg. 01	Corridor - Operiiriç	js					
Blug. 01	Based on observation	on, the facility failed to ensure	K 0	364	K364		12/02/2024
		or openings were free of	IX U.	30 4	The facility ensures corridor		12/02/2024
		equired by the LSC. Section			openings are free of transfer g	ırilles	
	_	grilles, regardless of whether			as required by the LSC.	,,,,,,,	
		y fusible link-operated			Transfer grilles in Nurses Stat	ion	
		be used in corridor walls or			was immediately removed and		
	_	cy could affect 14 residents			fixed on 11/25/2024.	•	
		rs near the Director of Nursing			All residents have the potentia	al to	
	office and Nurses S	_			be affected by this finding.	10	
					The maintenance director rece	eived	
	Findings Include:				in servicing education on		
	C				11/21/2024 on transfer grills a	nd	
	Based on observation	ons and interviews with the			fire hazards when it comes to		
	Maintenance Direct	or (MD) and Administrator			smoke.		
		facility on 11/21/24 between			The maintenance director and	/or	
	10:15 a.m. and 11:3	0 a.m., the wall between the			designee will monitor the trans	sfer	
	Director of Nursing	office and the Nurses Station			grilles weekly x4 weeks and		
	had a louvered vent	which also had several wires			monthly x2 months to ensure		
	running through it.	This opening would allow			there are no findings. The find	ings	
	smoke originating in	n the Director of Nursing's			of the monitoring will be report	ted	
	office to penetrate in	nto the nurse's station (which			to QAPI committee monthly by	/	
	is open to the corrid	lor.)			the maintenance director or hi	S	
	This finding was re-	viewed with the MD and			designee.		
		e time of discovery and again					
	at the exit conference	ce.					
	3.1-19(b)						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155532		(X2) MULTIPLE C A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 11/21/2024			
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 120 E MILLER DR BLOOMINGTON, IN 47401				
(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		
K 0511 SS=D Bldg. 01	NFPA 101 Utilities - Gas and						
	1 of 1 electrical light rooms were maintain condition. LSC 19. with Section 9.1. Light wiring and equipme National Electrical Carticle 314.28(3) (comprovided with cover suitable for the condition of the condition of the could affect 2 resides. Findings include: Based on observation Maintenance Direct during a tour of the 10:15 a.m. and 11:3 resident room # 12 and the cover was munaware the cover to This finding was resident.	ons and interviews with the or (MD) and Administrator facility on 11/21/24 between 0 a.m., the ceiling light fixture in had exposed wire on the ballast missing. The MD stated he was the ceiling light was missing. Wiewed with the MD and the time of discovery and again	K 0511	The facility ensures electrical lights are maintained in a safe operating condition. RM 12 light fixture immediatel fixed and placed in proper wo condition All residents have the potentiable affected by this finding. The maintenance director recin servicing education on the safety issue of the exposed was well as room rounding. The maintenance director and designee will monitor the light fixtures daily x 4 weeks, and weekly x2 months. The finding the monitoring will be reported QAPI committee monthly by the maintenance director or his designee.	yy rking al to eived ire, l/or gs of d to		
K 0712 SS=F Bldg. 01	NFPA 101 Fire Drills						
	failed to conduct fir quarters. LSC 19.7. conducted quarterly	riew and interview, the facility e drills on each shift for 3 of 4 1.6 states drills shall be on each shift to familiarize nurses, interns, maintenance	K 0712	K712 The facility ensures fire drills a conducted at unexpected time each shift at least quarterly Drills were gone through and			

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155532		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION <u>01</u>	(X3) DATE SURVEY COMPLETED 11/21/2024		
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	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	
K 0918	signals and emerger varied conditions. Tall staff and residen Findings include: Based on records re Maintenance Direct (AD) on 11/21/24 b the following shifts of a completed fire a) A second shift fire fourth quarters of 20 b) A first shift fire courth quarters of 20 do the required 12 documentation. Bas record review, the Mayere likely completed documer aforementioned drill This finding was record resident.	view and observation with the or (MD) and Administrator etween 8:30 a.m. and 1:00 p.m., were missing documentation drill: re drill in the second and 024 and 2023 (4th). It is the first, second and 024 and 2023 (4th). It is the first, second and 024 and 2023 (4th). It is the first, second and 024 and 2023 (4th). It is the first, second and 024 and 2023 (4th). It is were missing complete ed on interview at the time of MD and AD stated the drills red but could not find that it is to show the lis were conducted. Wiewed with the MD and the time of discovery and again		organized, missing drills found were added to the binder. Sor signature sheets needed. All residents have the potential be affected by this finding. The maintenance director recein servicing education on the importance of quarterly fire dribeing conducted on each shift. The maintenance director and designee will monitor the fire of monthly x3 months to ensure there are no findings and drills competed timely and accurate. The findings of the monitoring be reported to QAPI committee monthly by the maintenance director or his designee.	ne al to eived ills i. l/or drills s are ely. will	
SS=F Bldg. 01	Based on record rev failed to maintain 1 Standby System in a Standard for Emerg	riew and interview, the facility of 1 Emergency Power accordance with NFPA 110, ency and Standby Power	K 0918	K918 The facility ensures the emergency power system inspection, testing, and	12/23/2024	
		4.9, as required by NFPA 99 es Code, Section 6.4.1.1.6.1.		maintenance requirements are completed.	e	

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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>01</u>		COMPLETED		
155532		155532	B. WING			11/21/2024	
NAME OF PROVIDER OR SUPPLIER APERION CARE MONROE			STREET ADDRESS, CITY, STATE, ZIP COD 120 E MILLER DR BLOOMINGTON, IN 47401				
(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	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		8.4.9 states that all Level 1			All residents have the potentia	ıl to	
		Systems shall be tested at least			be affected by this finding.		
		ars. Where the assigned class			4 HR/36 month generator run	will	
	is greater than 4 hou	ars, it shall be permitted to			be completed on 12/23/2024.		
		ter 4 hours. NFPA 99 Section			Work from Evapar approved fi	rom	
		at Type 1 and Type 2 essential			preventative maint work on		
		wer sources shall be classified			machine.		
		, Level 1 generator sets.			Generator log documentation	will	
		es the minimum load for this			be filed with generator logs and		
	_	ed in 8.4.9.5.1, 8.4.9.5.2, or		attached.			
		ient practice could affect all		The maintenance director received			
	building occupants.				in servicing education on		
	Findings include:				emergency power system inspections, testing, and maintenance requirements an	d the	
	Based on records re	view and observation with the			required 4 HR/36 month gene		
		or (MD) and Administrator on			run.		
		:30 a.m. and 1:00 p.m., the			The administrator and/or design	gnee	
		cumentation for testing of the			will monitor the emergency po	-	
		or, however, could not provide			system logs monthly x three		
	documentation of a	three year 4 hour load test.			months. The findings of the		
	This was confirmed	by the MD, who stated he	monitoring will be reported to				
	was new to the facility and was unaware of the		QAPI committee monthly by the		ne		
	requirement.				maintenance director or his		
					designee.		
	This finding was reviewed with the MD and Administrator at the time of discovery and again at the exit conference. 3.1-19(b)				_		