STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155532	A. Building B. Wing	04/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aperion Care Monroe	120 E Miller Dr Bloomington, IN 47401

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. 34848 Based on interview and record review, the facility failed to ensure a resident was free from misappropriation of resident property though the diversion of a resident's controlled substance for staff use for 1 of 3 residents reviewed for misappropriation of property. (Resident B) Finding includes: During an interview on 4/5/24 at 9:30 a.m., the Minimum Data Set (MDS) Coordinator indicated on the morning of 3/2/24 she received a call from Licensed Practical Nurse (LPN) 1 who reported 2 cards of oxycodone (a narcotic medication) were missing for Resident B. She contacted all nurses who had worked that week and had them submit urine drug screens. On 3/4/24, all staff, with the exception of LPN 2 met and submitted urine drug screens. On 3/13/24, LPN 2 submitted a urine drug screen which tested positive for oxycodone, oxymorphone, and oxycodone/oxymorphone. On 4/5/24 at 10:30 a.m., Resident B's clinical record was reviewed. The diagnoses included, but were not limited to, sarcopenia (age-related progressive loss of muscle mass and strength), hemiplegia (paralysis) and hemiparesis (weakness) following unspecified cerebrovascular disease (a group of conditions that affect blood flow and the blood vessels in the brain) affecting left dominant side, pain disorder with related psychological factors, muscle weakness, lack of coordination, difficulty walking, type 2 diabetes mellitus with diabetic neuropathy (weakness, numbness, and pain from nerve damage, usually in the hands and feet), and major depressive disorder. A 3/21/24 Quarterly MDS assessment indicated the resident was prescribed a scheduled pain medication regimen, his pain frequency was occasional, and the pain intensity was rated a 6 out of 10, with 10 being the worst pain experienced. A 10/4/23 physician's order indicated Resident B was prescribed oxycodone-acetaminophen 10-325 milligrams, every 4 hours related to pain disorder with related psychological factors. A 2/26/24 pharmacy invoice indicated the resident had 174 tablets of oxycodone delivered at 3:41 p.m. On 4/5/24 at 10:15 a.m., the Administrator provided an undated Timeline for [Resident B's] oxycodone 10/325. The timeline indicated the following: (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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.

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

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 174 tables were received on 2/26/24 by LPN 5 and placed in the cart. Two cards (60 pills) were assigned one sheet of paper. In total, 6 cards of medication and 3 sheets of paper were placed in the medication cart. - On 2/26/24 at 6:00 p.m., cards and papers were counted by two staff. - On 2/27/24 at 6:00 a.m., cards and papers were counted by two staff. - On 2/27/24 at 6:00 p.m., cards and papers were counted by two staff. - On 2/28/24 at 6:00 a.m., cards and papers were counted by two staff. - On 2/28/24 at 6:00 p.m., cards and papers were counted by two staff. - On 2/29/24 at 6:00 a.m., cards and papers were counted by two staff. - On 2/29/24 at 6:00 p.m., cards and papers were counted by two staff. - On 3/1/24 at 6:00 a.m., cards and papers were not counted by two staff. - On 3/1/24 at 6:00 p.m., cards and papers were not counted by two staff. - On 3/2/24 at 6:00 a.m., cards and papers were counted and discovered missing by staff. A 3/13/24 specimen result certificate for LPN 2 indicated her urine tested positive for oxycodone, oxymorphone, and oxycodone/oxymorphone. The lab's final result disposition indicated the test was positive and they were unable to contact the donor. The test was verified on 3/20/24 at 8:39 a.m. A 3/1/24 electronic correspondence sent to the facility from the agency LPN 2 worked indicated she had violated their code of conduct policy high offense for a positive drug test resulting in termination of employment. LPN 3 was not able to be reach via telephone. A review of his written statement, dated 3/4/24 at 8:05 a.m., indicated he did not perform an oncoming narcotic count on 3/1/24. RN 1 was not able to be reached via telephone. A review of his written statement, dated 3/2/24, indicated on 3/1/24 at 6:00 p.m., he was unable to validated the number of the cards because it was not updated for days in the overflow box. On the morning of 3/2/24, during shift change, he tried to reconcile the number of cards and sheets with the day nurse. It was during this reconciliation when they discovered the missing oxycodone. During an interview on 4/5/24 at 9:40 a.m., the Director of Nursing indicated the on-coming and off-going shift nurses were to do a narcotic medication count together to ensure the medication count was accurate. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/5/24 at 11:25 a.m., Qualified Medication Aide (QMA) 1 indicated she did not do a narcotic count with LPN 2 on the front medication cart, only the back cart, which she was scheduled to work. She indicated LPN 3 was scheduled to work the front cart and he was running a little late. She assumed he would do a narcotic count with LPN 2 because that was his cart. During an interview on 4/5/24 at 12:26 p.m., LPN 4 indicated she noticed a discrepancy with the resident's numbered medication cards and narcotic sheets. The cards were labeled 1 through 6 and cards 3 and 4 were missing. She further indicated she knew the resident would have had a new oxycodone shipment delivered because she had to pull the medication from the emergency drug kit (EDK) the week prior. She was unable to locate cards 3 and 4. On 4/5/24 at 9:59 a.m., the Director of Nursing provided the facility policy, Narcotic/Controlled Substances-Counting, revised on 11/26/17, and indicated it was the policy currently being use. A review of the policy indicated, . count controlled substances with a partner and to verify the accuracy of the log sheets . 1. Always participate in the counting of the controlled substances at the beginning and ending of your shift . 3. Have partner assist in the count . 7. Count the remaining doses . 13. Listen while partner verifies the count . 19. Return keys to appropriate person . On 4/5/24 at 11:47 a.m., the Director of Nursing provided the facility policy, Residents' Rights, undated, and indicated it was the policy currently being use. A review of the policy indicated, . HH. The facility shall exercise reasonable care for the protection of residents' property from loss and theft . This deficient practice was corrected on 3/7/24 after the facility implemented a systemic plan that included the following actions: In servicing staff on counting narcotic medications and implementing ongoing monitoring of narcotic medication counting. This citation relates to Complaint IN00429694. 3.1-28(a)