| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155532 | A. Building<br>B. Wing | 08/06/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Aperion Care Monroe | 120 E Miller Dr<br>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) |
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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>Based on observation, interview, and record review, the facility failed to ensure staff prepared food in accordance with professional standards for food service safety for 1 of 2 kitchen observations. This had the potential to affect 31 out of 31 residents served from the kitchen.Findings include:During a kitchen tour on 8/3/25 at 10:45 a.m., a large pork loin was observed thawing in the bottom of a three compartment sink with running water flowing onto the meat. The meat was not submerged in water and the water was flowing down the drain.During an interview on 8/6/25 at 12:25 p.m., the Dietary Manager indicated the cook should have had the meat in a deep pot while the water was running onto the meat. On 8/3/25 at 11:05 a.m., the Administrator provided the facility policy, Thawing Foods, and indicated it was the policy currently being used. A review of the policy indicated, . 4. Thawing foods under cool running potable water (This process is not recommended and should only be used in an emergency and if you cook food immediately) . b. Food items should be completely submerged under running water .3.1-21(i)(3) |

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 0921<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.<br><br>Based on observations, interviews, and clinical records, the facility failed to ensure flies and gnats were not present in 1 of 10 resident rooms (Resident 5, Resident 6, Resident 25), sit to stand lift foot platforms were clean for 2 of 2 sit to stand lifts used by 3 residents (Resident 2, Resident 17, Resident 26), and exposed wires were covered for 1 of 4 communal resident bathrooms observed for environmental concerns. Findings include: 1. On 8/3/25 at 1:47 p.m., 8/5/25 at 2:20 p.m., and 8/6/25 at 10:15 a.m., gnats and flies were observed in the room of Resident 5, Resident 6, and Resident 25 on the privacy curtains, walls, bedside tables, and the residents themselves. During an interview on 8/16/25 at 10:17 a.m., Resident 6 indicated there were flies and gnats in the room all the time unless it was wintertime. During an interview on 8/16/25 at 10:18 a.m., Resident 25 indicated there were almost always gnats and flies in the room. He frequently fashioned a fly and gnat swatter out of paper to combat the pests. 2. On 8/3/25 at 9:45 a.m. and 2:50 p.m., and 8/4/25 at 9:30 a.m. and 1:05 p.m. debris and food crumbs were observed on the foot platform of a sit to stand lift on the East Hall and the foot platform of a sit to stand lift on the North Hall. 3. On 8/3/25 at 10:00 a.m. and 2:40 p.m., electrical wires with wire nuts on them were observed emerging approximately 8 feet high on the north wall of the southeast resident bathroom. During an interview on 8/4/25 at 1:15 p.m., the Administrator indicated the sit to stand lift platforms had debris and food crumbs on them and were in need of cleaning, and the wires emerging from the wall of the southeast resident bathroom required a cover. During an interview on 8/6/25 at 11:00 a.m., the Administrator indicated the room of Resident 5, Resident 6, and Resident 25 had gnats and flies and was in need of an effective plan to eliminate the pests. On 8/3/25 at 11:15 a.m., the Administrator provided the Resident Rights, undated, and indicated these were the Resident Rights currently used by the facility. A review of the Resident Rights indicated, .you have the right to a safe, clean, comfortable, and homelike environment . 3.1-19(f) |

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| F 0552<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that residents are fully informed and understand their health status, care and treatments.<br><br>Based on record review and interview, the facility failed to ensure residents have the right to be informed of and participate in their treatment for 2 of 6 residents reviewed for unnecessary medications. (Resident 7 and Resident 33)Findings include:1. On 8/5/25 at 11:00 a.m., Resident 7's clinical record was reviewed. The diagnoses included, but were not limited to, schizoaffective disorder (a condition characterized by a combination of schizophrenia and mood disorder symptoms), psychosis (a mental health condition where a person experiences a disconnect from reality), generalized anxiety disorder, major depressive disorder, and dementia (a decline in mental ability severe enough to interfere with daily life).A review of the physician's orders indicated the following:On 7/8/25, an order for Lorazepam (a medication used to treat anxiety) 1 mg (milligram) twice daily was prescribed for generalized anxiety disorder.On 7/9/25, an order for Cymbalta (a medication used to treat depression) 60 mg once daily, to be taken with Cymbalta 30 mg to equal 90 mg, was prescribed for major depressive disorder.On 7/9/25, an order for Cymbalta 30 mg once daily, to be taken with Cymbalta 60 mg to equal 90 mg, was prescribed for major depressive disorder.A review of a psychiatry provider note, dated 7/8/25, indicated Cymbalta was increased to 90 mg on 7/8/25, due to resident refused all other medications for depressive disorder. The provider note also indicated Ativan (lorazepam) was increased to 1 mg twice daily on 7/8/25 for generalized anxiety.The clinical record lacked documentation that indicated informed consent was provided to the resident and/or the resident representative, regarding treatment options, risks, and benefits of psychotropic medication prior to the increase in psychotropic medications.During an interview with the DON (Director of Nursing) on 8/6/25 at 12:25 p.m., she indicated there was not an informed consent obtained prior to the increase of psychotropic medications. 2. On 8/5/25 at 1:45 p.m., Resident 33's clinical record was reviewed. The diagnoses included, but were not limited to, dementia and major depressive disorder.A review of the physician's orders indicated the following:On 7/22/25 an order for Sertraline (brand name Zoloft, medication used to treat depression) 100 mg once daily was prescribed for major depressive disorder.A review of a psychiatry provider note, dated 7/22/25, indicated the resident's major depressive disorder, was persistent as evidenced by irritability. The provider also indicated Zoloft was increased to 100 mg daily on 7/22/25.The clinical record lacked documentation that indicated informed consent was provided to the resident and/or the resident representative, regarding treatment options, risks, and benefits of psychotropic medication prior to the increase in psychotropic medications.During an interview with the DON (Director of Nursing) on 8/6/25 at 12:25 p.m., she indicated there was not an informed consent obtained prior to the increase of psychotropic medications. On 8/6/25 at 12:40 p.m., the Administrator provided a copy of the facility policy named, Psychotropic Medication-Gradual Dosage Reduction, dated 2/1/18, she indicated this was a current policy used by the facility. A review of the policy indicated, .Informed consent shall be obtained as follows: a) Psychotropic medications shall not be administered without the informed consent of the resident or the authorized resident representative . d) Side effects and dosage of the medication shall be described .3.1-3(n)(2) |

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| F 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.<br><br>Based on observation, interview, and record review, the facility failed to ensure the resident's representative and physician was notified of significant weight loss for 1 of 3 residents reviewed for nutrition. (Resident 25)Findings include: During an interview on 8/3/25 at 1:44 p.m., Resident 25 indicated in the last month, he had lost weight. On 8/5/25 at 12:24 p.m., Resident 25 was observed to be eating lunch. On 8/5/25 at 11:09 a.m., Resident 25's clinical record was reviewed. The diagnoses included, but were not limited to, schizophrenia and hypertension. Resident 25's weight indicated the following:-On 6/3/25, Resident 25 weighed 156 pounds -On 7/9/25, Resident 25 weighed 144 pounds which was a 7.69% weight loss in a month. -On 7/28/25, Resident 25 weighed 140 pounds. The care plan, dated 1/20/23, indicated Resident 25 was at nutritional risk due to schizophrenia. The intervention was to report to the physician as needed of significant weight loss of 5% or greater in a month and to weigh resident and record as ordered. The Nutrition Progress note, dated 7/10/25 at 10:17 am, indicated Resident 25's weight was 144 pounds on 7/9/25 which was a 7.7% weight loss in 30 days. He was on a mechanical soft diet with ice cream at lunch and dinner and double eggs at breakfast. The note lacked documentation the responsible party or the physician was notified of the significant weight loss. The progress notes dated 7/6/25 through 8/6/25 lacked documentation of the responsible party or physician notification of the significant weight loss. The clinical record lacked documentation of a Comprehensive Clinical Review meeting, dated for 7/16/25. The Comprehensive Clinical Review Meeting, dated 7/23/25 at 5:26 p.m., indicated the responsible party and nurse practitioner was notified which was 14 days after significant weight loss. During an interview on 8/6/25 at 10:08 a.m., the Director of Nursing indicated the responsible party would be notified of weight loss after the first weekly Comprehensive Clinical review meeting. During an interview on 8/6/25 at 11:33 a.m., DON indicated Resident 25's weight in June 2025 was 156 pounds and on 7/9/25 his weight was 142 pounds. The clinical record lacked documentation of the responsible party or physician notification of weight loss until 7/23/25. On 8/6/25 at 1:50 p.m., the Administrator provided the facility policy, Physician - Family Notification - Change in Condition, revised date of 11/13/18 and indicated it was the policy currently being used by the facility. A review of the policy indicated, The facility will inform the .notify the resident's legal representative .(C) A need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment) . On 8/6/25 at 1:50 p.m., the Administrator provided the facility policy, Weights, revised date of 10/17/19 and indicated it was the policy currently being used by the facility. A review of the policy indicated, Undesired or unanticipated weight gains/loss of 5% in 30 days, 7.5% in three months, or 10% in six months shall be reported to the physician . 3.1-5(a)(2) |

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| F 0640<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Encode each resident?s assessment data and transmit these data to the State within 7 days of assessment.<br><br>Based on interview and record review, the facility failed to ensure staff submitted a comprehensive assessment within 14 days of a resident's discharge for 1 of 15 residents reviewed for MDS assessments and timing (Resident 13).Finding includes: On 8/4/25 at 10:19 a.m., Resident 13's clinical record was reviewed. The diagnoses included, but were not limited to dementia, Alzheimer's disease, and sacral pressure ulcer. A 7/17/25 progress note indicated the resident was sent to the hospital for a bleeding sacral wound and was admitted after she had wound surgery to stop the bleeding. A 7/17/25 discharge MDS (Minimum Data Set) assessment was listed as 'in process' and incomplete. The assessment reference date (ARD) was 7/17/25. During an interview on 8/6/25 at 1:19 p.m., the Director of Nursing indicated the facility was aware of the incomplete MDS assessment and the corporate staff was working to complete it. |

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| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident receives an accurate assessment.<br><br>Based on record review and interview, the facility failed to ensure an accurate assessment for 1 of 15 residents reviewed for MDS (Minimum Data Set) assessment accuracy. (Resident 27)Findings include: On 8/4/25 Resident 27's clinical record was reviewed. The diagnoses included, but were not limited to, traumatic brain injury (an injury to the brain caused by an external force) and major depressive disorder. A review of the physician orders dated 3/25/25, indicated Resident 27 was prescribed Alprazolam (a medication used to treat anxiety disorders) for a diagnosis of anxiety. The resident's MAR indicated this remained an active order. A review of the provider progress note, dated 6/10/25, indicated the resident had an active diagnosis of anxiety. A review of the Resident 27's care plan, dated 9/16/24, indicated the resident used anti-anxiety medications.A review of the Quarterly MDS assessment, dated 6/30/25, indicated anxiety was not marked as an active diagnosis. During an interview with the DON (Director of Nursing) on 8/6/25 at 9:40 a.m., she indicated the resident had an active diagnosis of anxiety disorder on 6/30/25. The DON indicated the Quarterly MDS assessment, dated 6/30/25, was marked no for a diagnosis of anxiety disorder and it should have been marked yes. During an interview with the Administrator on 8/6/25 at 11:30 a.m., she indicated the facility did not have a MDS policy and they utilized the RAI (Resident Assessment Instrument) tool to complete MDS assessments.A review of the RAI, Version 3.0 User's Manual, 10/2024, on 8/6/25 at 12:00 p.m., indicated for section I5700, Anxiety Disorder, .Diagnosis status: Active or Inactive is a 7-day look-back period .Ongoing therapy with medications or other interventions to manage a condition that requires monitoring for therapeutic efficacy or to monitor potentially severe side effects in the last 7 days .3.1-31(d) |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide enough food/fluids to maintain a resident's health.<br><br>Based on observation, interview, and record review, the facility failed to ensure resident received nutritional supplement for a resident with an assessed weight loss for 1 of 3 residents reviewed for nutrition. (Resident 25)Findings include: During an interview on 8/3/25 at 1:44 p.m., Resident 25 indicated in the last month he had lost weight. On 8/4/25 at 12:42 p.m., Resident 25 was observed to be resting in his bed. His lunch tray was observed to be in his room with no ice cream on the lunch tray. On 8/5/25 at 12:24 p.m., Resident 25 was observed to be eating lunch. No ice cream was observed on his lunch tray or on his meal ticket. During an interview on 8/5/25 at 1:45 p.m., Resident 25 indicated he did not get ice cream on his lunch tray. On 8/5/25 at 11:09 a.m., Resident 25's clinical record was reviewed. The diagnoses included, but were not limited to schizophrenia and hypertension. The quarterly Minimum Data Set (MDS) assessment, dated 6/26/25, indicated Resident 25 was cognitively intact. Resident 25's weight indicated the following:-On 6/3/25, Resident 25 weighed 156 pounds -On 7/9/25, Resident 25 weighed 144 pounds which was a 7.69% weight loss in a month. The care plan, dated 1/20/23, indicated Resident 25 was at nutritional risk due to schizophrenia. The intervention was to provide supplements as ordered. The Nutrition Progress note, dated 7/10/25 at 10:17 am, indicated Resident 25's weight was 144 pounds on 7/9/25 which was 7.7% in 30 days. He was on a mechanical soft diet with ice cream at lunch and dinner and double eggs at breakfast. On 8/6/25 at 12:10 p.m., Resident 25 was observed to be feeding himself lunch. His tray was observed not to have ice cream. On 8/6/25 at 12:17 p.m., the Dietary Manager was observed to be placing a dish of ice cream on Resident 25's lunch tray. At that time, she indicated she forgot Resident 25's ice cream on his lunch tray. The ice cream was to come out on his lunch trays. On 8/6/25 at 1:50 p.m., the Administrator provided the facility policy, Weights, revised date of 10/17/19 and indicated it was the policy currently being used by the facility. A review of the policy lacked documentation of nutritional supplements. 3.1-46(a)(2) |