

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 013327	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 04/16/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER APERION ESTATES PERU, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1200 KITTYHAWK DRIVE PERU, IN 46970
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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) COMPLETE DATE
--------------------	--	---------------	---	--------------------

{R 000}	<p>INITIAL COMMENTS</p> <p>This visit was for a Post Survey Revisit (PSR) to the State Residential Survey completed on March 4, 2015.</p> <p>Survey date: April 16, 2015</p> <p>Facility number: 013327 Provider number: 013327 AIM number: N/A</p> <p>Census bed type: Residential: 20 Total: 20</p> <p>Residential sample: 1</p> <p>Aperion Estates Peru, LLC was found to be in compliance with 410 IAC 16.2-5 in regard to the PSR to the State Licensure Survey.</p>	{R 000}		
---------	--	---------	--	--

Indiana State Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
---	-------	-----------