PRINTED: 12/20/2024

CENTERS FOR	OMB NO. 0938-039						
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155799		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY  COMPLETED  11/15/2024		
NAME OF PROVIDER OR SUPPLIER  APERION CARE MARION LLC			STREET ADDRESS, CITY, STATE, ZIP COD 614 WEST 14TH STREET MARION, IN 46953				
(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 APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE		
F 0000							
Bldg. 00	IN00446556 and I	46556 - No deficiencies related to	F 0000				
	Complaint IN004	46339 - Federal/State deficiencies gations are cited at F726 an F760.					
	Survey dates: No	vember 14 and 15, 2024					
	Facility number: ( Provider number: AIM number: 201	155799					
	Census Bed Type: SNF: 6 SNF/NF: 51 Residential: 14 Total: 71						
	Census Payor Typ Medicare: 6 Medicaid: 8 Other: 43 Total: 57	pe					
	These deficiencies accordance with 4	s reflect State Findings cited in 10 IAC 16.2-3.1.					
	Quality review co	mpleted November 25, 2024.					
F 0726 SS=D Bldg. 00	483.35(a)(3)(4)(d) Competent Nurs						
		w and record review, the facility ursing staff were competent in	F 0726	Tag number: F726 I. What corrective action(	12/05/2024		

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

TITLE (X6) DATE

Tamera Shirels ED 12/12/2024

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		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		COMPLETED		
		155799	B. WING			11/15/2024	
				STDEET /	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF PROVIDER OR SUPPLIER					EST 14TH STREET		
APERION CARE MARION LLC					N, IN 46953		
AI ENIOI	A OUTTE MINIMINION F			IVIAINIO	in, iin 40900		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG DEFICIENCY)			DATE
		of controlled medications as			will be accomplished for those	:	
	_	administering two opioid			residents found to have been		
	analgesics together	to a resident (Resident B).			affected by the deficient practi	y the deficient practice;	
					Resident B was assessed, no		
	Findings include:				negative outcomes identified.		
					Medication orders and care pl	ans	
		for Resident B was reviewed			reviewed and updated as requ	ıired.	
		7 a.m. Diagnoses included	1		Notified family and physician.		
		nal stenosis, type 2 diabetes,					
	~	l atrophy, abnormalities of gait					
	and mobility, and d	epression.					
					II. How other residents ha	ving	
	-	r October 2024 indicated the			the potential to be affected by	the	
	resident had an orde				same deficient practice will be		
	-	minophen (opioid analgesic)			identified and what corrective		
		hours as needed for pain, dated			action(s) will be taken; All		
		ntinued on 10/18/24. An order			residents residing in the facility	y	
		e (opioid analgesic) 4 mg every			have a potential to be affected	l.	
		or severe pain was dated			Medication orders and care pl	ans	
	10/11/24 and discontinued 10/18/24.				will be reviewed and updated		
					required, daily Monday-Friday		
		lministration Record (MAR) for			clinical meeting, by printing of	f	
	October 2024 indic	ated the following for Resident			daily order report.		
	B:						
	a. RN 1 administere		1		l		
	-	minophen 10-325 mg on			III. What measures will be	put	
-		o.m. On 10/12/24 at 10:35 p.m.,			into place and what systemic		
		ng was given. The pain rate			changes will be made to ensu		
documented was 8 out of 10.		out of 10.			that the deficient practice does		
	t DNI-1	d handan and a mark to the			recur; All nurses and qualified	1	
		d hydrocodone-acetaminophen			medication assistants were		
		fromorphone 4 mg on 10/13/24			educated on prevention of		
		pain rate documented was 10	1		medication errors for narcotics	and	
	out of 10.				medication administration.		
	- DNI 1 . 1 . 1 . 1 . 4	_ 1			on-going education with		
	c. RN 1 administere						
	-	minophen 10-325 mg and					
		ng on 10/17/24 at 1:08 a.m. The			] , , , , ,		
	pain rate document	ed was 8 out of 10.	1		IV. How the corrective		I

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AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		a. building <u>00</u>		COMPLETED		
155799		B. WING 11/15/2024			/2024			
NAME OF D	PROVIDER OR SUPPLIER	,		STREET A	ADDRESS, CITY, STATE, ZIP COD			
					EST 14TH STREET			
APERION	N CARE MARION L	LC		MARIO	N, IN 46953			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX				PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	.TE	COMPLETION	
TAG			_	TAG	DEFICIENCY)		DATE	
	d. RN 1 administere	ad.			action(s) will be monitored to	e ili		
		minophen 10-325 mg on			ensure the deficient practice v not recur i.e., what quality	/III		
	•	n. At 7:40 p.m. on 10/17/24,			assurance program will be put	t into		
	_	ng was given. The pain rate			place; The Director of	. II ILO		
	documented was 8				Nursing/Designee will review	ا ااد		
	documented was o	out 01 10.			new admission orders for	all		
	RN 1 was unavailal	ole for interview during the			accuracy and documentation.			
	survey.	ore for meet view during the			Any noted issues will be			
	301.57.				immediately addressed by 1:1			
	During an interview on 11/15/24 at 2:13 p.m., the DON indicated hydrocodone-acetaminophen and hydromorphone should not be given together.				education and or disciplinary			
					action.			
	Review of a Nation	al Institute on Drug Abuse			The results of these audits wil	l be		
	article "Opioids," da	ated November 2024 and			reviewed in Quality Assurance	<b>;</b>		
	retrieved from				Meeting monthly x6 months or	r		
	https://nida.nih.gov/	/research-topics/opioids#heal			until an average of 90%			
		he following: "Taking			compliance or greater is achie			
	-	drugs raises the likelihood of			x3 consecutive months. The			
		associated with opioids,			Committee will identify any tre	nds		
	including risk of overdose, can be even greater when a person uses more than one drug"				or patterns and make			
					recommendations to revise th			
	This citation relates to Complaint IN00446339.				plan of correction as indicated			
	This citation relates	to Compiant 11100440339.						
	3.1-13(r)(2)							
F 0760	483.45(f)(2)							
SS=E Bldg. 00	, , , ,	e of Significant Med Errors						
	Based on record rev	view and interview, the facility	F 0'	760	Tag number: F760		12/05/2024	
		ignificant medication		, 00	I. What corrective action	(s)	12/03/2021	
	administration error for 1 of 5 residents reviewed				will be accomplished for those	` '		
	for medication administration. (Resident B)				residents found to have been			
	Findings include:				affected by the deficient practi Resident B was assessed, no			
	i mangs metade.				negative outcomes identified.			
	The clinical record	for Resident B was reviewed			Medication orders and care pl	ans		
	on 11/14/24 at 11:27 a.m. Diagnoses included				reviewed and updated as requ			

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NAME OF F	ROVIDER OR SUPPLIEF	· {	•		ADDRESS, CITY, STATE, ZIP COD			
APERION CARE MARION LLC			614 WEST 14TH STREET MARION, IN 46953					
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TAG	REGULATORY OR LSC IDENTIFYING INFORMATION cervical region spinal stenosis, type 2 diabetes,			TAG		Notified family and physician.		
		l atrophy, abnormalities of gait			Notified fairlify and physician.			
	and mobility, and d							
	Physician orders for October 2024 indicated the resident had an order for hydrocodone-acetaminophen (opioid analgesic) 10-325 mg every 6 hours as needed for pain, dated 10/10/24 and discontinued on 10/18/24. An order for hydromorphone (opioid analgesic) 4 mg every 4 hours as needed for severe pain was dated 10/11/24 and discontinued 10/18/24.  The Medication Administration Record (MAR) for October 2024 indicated the following for Resident B:				II. How other residents hat the potential to be affected by same deficient practice will be identified and what corrective action(s) will be taken; All residents residing in the facility have a potential to be affected Medication orders and care p will be reviewed and updated required, daily Monday-Friday clinical meeting, by printing of daily order report.	y I. lans as in		
	<ul> <li>a. RN 1 administered hydrocodone-acetaminophen 10-325 mg on 10/12/24 at 10:38 p.m. On 10/12/24 at 10:35 p.m.,hydromorphone 4 mg was given. The pain rate documented was 8 out of 10.</li> <li>b. RN administered hydrocodone-acetaminophen 10-325 mg and hydromorphone 4 mg on 10/13/24 at 11:49 p.m. The pain rate documented was 10 out of 10.</li> </ul>				III. What measures will be into place and what systemic changes will be made to ensu that the deficient practice does recur; All nurses and qualified medication assistants were educated on prevention of medication errors and followin policy of medication administration.	re s not		
	hydromorphone 4 r pain rate document d. RN 1 administer hydrocodone-acetar 10/17/24 at 7:23 p.1	minophen 10-325 mg and mg on 10/17/24 at 1:08 a.m. The ed was 8 out of 10.  ed minophen 10-325 mg on m. At 7:40 p.m. on 10/17/24, mg was given. The pain rate			IV. How the corrective action(s) will be monitored to ensure the deficient practice v not recur i.e., what quality assurance program will be put place; The Director of Nursing/Designee will review a new admission orders for	into		
	RN 1 was unavailable for interview during the				accuracy and documentation. Any noted issues will be			

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Event ID:

2IB311

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155799	X2) MULTIPLE CONSTRUCTION A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 11/15/2024			
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	`			immediately addressed by 1:1 education and or disciplinary action.  The results of these audits will reviewed in Quality Assurance Meeting monthly x6 months of until an average of 90% compliance or greater is achie x3 consecutive months. The Committee will identify any tre or patterns and make recommendations to revise the plan of correction as indicated.	ll be e r eved QA ends			

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