STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155799	A. BUILDING 00 B. WING	02/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
APERION CARE MARION LLC	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00450664, IN00451195, IN00451756, IN00452136, and IN00452298. Complaint IN00450664 - No deficiencies related to the allegations are cited. Complaint IN00451195 - No deficiencies related to the allegations are cited. Complaint IN00451756 - Federal/state deficiencies related to the allegations are cited at F839 and F9999. Complaint IN00452136 - No deficiencies related to the allegations are cited. Complaint IN00452298 - No deficiencies related to the allegations are cited. Survey dates: January 31, 2025 and February 3, 2025 Facility number: 012809 Provider number: 155799 AIM number: 201136580 Census Bed Type: SNF/NF: 47 SNF: 8 Total: 55 Census Payor Type: Medicare: 8 Medicaid: 5 Other: 42 Total: 55	F 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Tamera Shirels	ED	02/20/2025

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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	These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed February 10, 2025.			
F 0839 SS=D Bldg. 00	483.70(f)(1)(2) Staff Qualifications Based on record review and interview, the facility failed to ensure the active licensure of a Practical Nurse (PN) who provided care to residents for 1 of 55 employees reviewed for active licensure. (PN 2) Findings include: During Employee Record Review, PN 2's nursing license was indicated as expired on 10/31/24 on the MyLicense.IN.gov website, accessed on 1/31/25 at 11:20 a.m. PN 2 worked as a nurse, providing resident care, following the expiration of her licensure on the following dates: November 4, 5, 8, 9, 10, 13, 14, 18, 19, 22, 23, 24, 27, and 28, 2024. December 2, 3, 6, 7, 8, 11, 12, 16, 17, 20, 21, 22, 25, 26, 30, and 31, 2024. January 3, 4, 5, 8, 9, 13, 14, 17, 18, 19, 22, 23, 27, 28, and 31, 2025. During an interview on 2/3/25 at 3:52 p.m., the DON indicated human resources was responsible for tracking staff licensure. PN 2 was allowed to continue working in her role as an LPN due to the facility not realizing her licensed had expired. She should not have been on the schedule until her	F 0839	Date of compliance: 02/24/2025 Tag number: F839 I What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Licensures were checked on all employees that have them to ensure they are active. II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; Licensure book for Aperion Care Marion was brought up to date with copies III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; Human Resource Manager, Director of Nursing, Assistant Director of Nursing and nursing schedular were all in-serviced on	02/24/2025

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	licensure was updated and valid. The facility followed state and federal regulations as the policy for licensure of resident care staff when indicated. This citation relates to complaint IN00451756. 3.1-14(s)		checking for active licensures and removing from schedule until the license is active. IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; Executive Director/designee will monitor Licensure book monthly and will remind any staff who are due weekly until the license is renewed, this will be ongoing. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	
F 9999 Bldg. 00	3.1-14 PERSONNEL (k) There shall be an organized ongoing inservice education and training program planned in advance for all personnel. This	F 9999	Date of compliance: 02/24/2025 Tag number: F9999 I. What corrective action(s) will be accomplished for those	02/24/2025

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	training shall include, but not be limited to, the following: (1) Residents' rights. (2) Prevention and control of infection. (3) Fire prevention. (4) Safety and accident prevention. (5) Needs of specialized populations served. (6) Care of cognitively impaired residents. (l) The frequency and content of inservice education and training programs shall be in accordance with the skills and knowledge of the facility personnel as follows. For nursing personnel, this shall include at least twelve (12) hours of inservice per calendar year and six (6) hours of inservice per calendar year for nonnursing personnel. This State Rule was not met as evidenced by: Based on record review and interview, the facility failed to ensure annual resident rights and abuse training was completed for 2 of 5 employee files reviewed for required annual training. (CNA 2, ADON) Findings include: Facility employee files were reviewed on 2/3/25 at 2:05 p.m., and indicated the following: a. CNA 2 had a hire date of 7/25/22. Her training record lacked annual training for abuse in 2024. b. The ADON had a hire dated of 8/10/20. Her training record laced annual training for resident rights for 2024. During an interview on 2/3/25 at 3:52 p.m., the DON indicated the facility staff were to complete inservice training each year. This information was		residents found to have been affected by the deficient practice; Audit was done of all employees to determine who had not completed their resident rights and abuse training. II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; Department managers were given a list of their employees who are required to do their resident rights and abuse trainings and staff are required to have trainings done by 02/21/2025 III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; Upon hire abuse and resident rights will be completed by the new employee during orientation and they will not be able to work in their department until completed. IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; Human Resources will print a list of trainings that need to	

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	tracked by human resources. Abuse training and resident rights training were included in required training. The facility followed the State and Federal Regulations regarding staff education as their policy. This citation relates to Complaint IN00451756.		be done weekly and will distribute them to the employee's manager. The executive director will audit the list weekly to ensure all trainings are up to date for each week. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	