STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155820	A. BUILDING -- B. WING	04/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
APERION CARE LINCOLN	1236 LINCOLN AVE EVANSVILLE, IN 47714

(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
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 04/30/25 Facility Number: 000443 Provider Number: 155820 AIM Number: 100289580 At this Emergency Preparedness survey, Aperion Care Lincoln was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 47 certified beds, with a current census of 46. Quality Review completed on 05/05/25 The requirement at 42 CFR, Subpart 483.73 is NOT MET as evidenced by:	E 0000	By submitting the enclosed material, we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility respectively requests the plan of correction to be considered our allegation of compliance **effective May 16th, 2025** to the State findings of the Complaint survey conducted on May 16th, 2025. We respectfully request a desk review in lieu of a post-survey review.	
E 0004 SS=F Bldg. --	403.748(a), 416.54(a), 418.113(a), 441.1 Develop EP Plan, Review and Update Annually Based on record review and interview, the facility failed to develop and maintain an emergency preparedness plan that was reviewed and updated completely at least annually in accordance with 42 CFR 483.73(a). This deficient practice could affect all residents in the facility. Findings include: Based on review of the Emergency Preparedness	E 0004	**1) Immediate actions taken for those residents identified:** No Residents were identified in the deficiency **2) How the facility identified other residents:** All residents have the potential to be affected by the alleged deficient	05/16/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Dena Kerschner	RVPO	05/16/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155820	A. BUILDING -- B. WING	04/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
APERION CARE LINCOLN	1236 LINCOLN AVE EVANSVILLE, IN 47714

(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
	Manual on 04/30/25 at 1:10 p.m. with the Regional Vice President of Operations, Administrator and Maintenance Director present, the facility did provide an emergency preparedness manual that had an overall review and update date of 11/18/24, however, other than the review and update page at the front of the manual (Page 2), the name of the facility was always listed under the previous name throughout the entire Emergency Preparedness Manual. Based on interview at 1:10 p.m., this was acknowledged by the Regional Vice President of Operations, Administrator, and Maintenance Director. Furthermore, the Regional Vice President of Operations said the name of the facility changed about a year ago. This finding was reviewed with the Regional Vice President of Operations, Administrator, and Maintenance Director during the exit conference.		practice. Pages have been with correct name and date of review added and will be updated annually to ensure ongoing compliance **3) Measures put into place/ System changes:** Maintenance Director has been educated on updating the name and dates on EP and to continue to update annually and as needed to ensure ongoing compliance. **4) How the corrective actions will be monitored:** Admin/Designee will complete audit of EP plans 3x a week for 4 weeks then every other week for 8 weeks then monthly times 3 months to ensure EP plans have required information and are updated and reviewed **The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 100 % 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.**	
E 0025 SS=F	403.748(b)(7), 418.113(b)(5), 441.184(b) Arrangement with Other Facilities			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155820	A. BUILDING -- B. WING	04/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
APERION CARE LINCOLN	1236 LINCOLN AVE EVANSVILLE, IN 47714

(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
Bldg. --	Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include the development of arrangements with other Long Term Care (LTC) facilities and other providers to receive residents in the event of limitations or cessation of operations to maintain the continuity of services to LTC residents in accordance with 42 CFR 483.73(b)(7). This deficient practice could affect all occupants. Findings include: Based on review of the Emergency Preparedness Manual (EPM) on 04/30/25 at 1:00 p..m. with the Regional Vice President of Operations, Administrator, and Maintenance Director present, documentation of emergency preparedness policies and procedures including the development of arrangements with other LTC facilities and other providers to receive residents in the event of limitations or cessation of operations was available for review, however, one of the LTC facilities listed in the EPM has not been in operation for over a year, and the other facility listed had an ownership/name change over a year ago. Based on interview at 1:00 p.m., the Regional Vice President of Operations, Administrator, and Maintenance Director acknowledged facilities listed in the EPM were not current and need to be updated. This finding was reviewed with the Regional Vice President of Operations, Administrator and Maintenance Director during the exit conference.	E 0025	**What corrective actions have been accomplished for those residents found to have been affected by the deficient practice.** No residents were affected by the alleged deficient practice **How the facility will identify other residents having the potential to be affected by the same deficient practice:** All residents have potential to be affected by the alleged deficient practice **3) Measures put into place/ System changes:** Maintenance Director /Administrator have been educated on updating and maintaining emergency transfer agreements. Updated transfer agreements have been obtained. Monitoring to be completed by Admin/designee to ensure ongoing compliance. **4) How the corrective actions will be monitored:** Admin/Designee will complete audit of transfer agreement plans for 4 weeks then every other week for 8 weeks then monthly times 3 months to ensure EP plans have required information and are updated and reviewed **The results of these audits will be reviewed in Quality**	05/16/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155820	A. BUILDING -- B. WING	04/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
APERION CARE LINCOLN	1236 LINCOLN AVE EVANSVILLE, IN 47714

(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
			Assurance Meeting monthly x6 months or until an average of 100 % 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.	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 04/30/25 Facility Number: 000443 Provider Number: 155820 AIM Number: 100289580 At this Life Safety Code survey, Aperion Care Lincoln was found not in compliance with Requirements for Participation in Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This two story facility with a ground level was determined to be of Type II (222) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detectors on all levels including the corridors, spaces open to the corridors, and all resident sleeping rooms. The facility has a capacity of 47 and had a census of	K 0000	By submitting the enclosed material, we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility respectively requests the plan of correction to be considered our allegation of compliance **effective May 16th, 2025** to the State findings of the Complaint survey conducted on May 16th, 2025. We respectfully request a desk review in lieu of a post-survey review.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155820	A. BUILDING 01 B. WING	04/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
APERION CARE LINCOLN	1236 LINCOLN AVE EVANSVILLE, IN 47714

(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
	46 at the time of this survey. All areas where the residents have customary access were sprinklered and all areas providing facility services were sprinklered, except one brick framed garage used for facility storage. Quality Review completed on 05/05/25			
K 0345 SS=F Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance Based on record review and interview, the facility failed to ensure 34 of 211 smoke detectors that failed the sensitivity test were replaced. NFPA 72, National Fire Alarm Code, 2010 Edition, Section 14.4.5.3.1 states detector sensitivity shall be checked within 1 year of installation, and every alternate year thereafter. After the second required calibration test, if sensitivity tests indicate that the detector has remained within its listed and marked sensitivity range, the length of time between calibration tests shall be permitted to be extended to a maximum of 5 years. If the frequency is extended, records of detector caused nuisance alarms and subsequent trends of these alarms shall be maintained. In zones or areas where nuisance alarms show an increase over the previous year, calibration tests shall be performed. To ensure that each smoke detector is within its listed and marked sensitivity range, it shall be tested using any of the methods: (1) Calibrated test method. (2) Manufacturer's calibrated sensitivity test instrument. (3) Listed control equipment arranged for the purpose. (4) Smoke detector/fire alarm control unit arrangement whereby the detector causes a signal at the control unit where its sensitivity is outside	K 0345	**1) Immediate actions taken for those residents identified:** No Residents were affected by alleged deficient practice **2) How the facility identified other residents:** All residents have the potential to be affected by the alleged deficient practice. **3) Measures put into place/ System changes:** Contract signed with vendor to replace failed smoke detectors. Maintenance Dir/Admin educated on importance of ensuring smoke detectors replaced quickly with failed inspection. **4) How the corrective actions will be monitored:** Admin/Designee will complete daily audit of Fire alarm system inspection for 4 weeks then every other week for 8 weeks then	05/16/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155820	A. BUILDING 01 B. WING	04/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
APERION CARE LINCOLN	1236 LINCOLN AVE EVANSVILLE, IN 47714

(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
	its listed sensitivity range. (5) Other calibrated sensitivity method acceptable to the authority having jurisdiction. Detectors found to have sensitivity outside the listed and marked sensitivity range shall be cleaned and recalibrated, or replaced. The detector sensitivity cannot be tested or measured using any spray device that administers an unmeasured concentration of aerosol into the detector. This deficient practice could affect all residents, staff, and visitors in the facility. Findings include: Based on record review on 04/30/25 at 11:40 a.m. with the Maintenance Director present, the facility was able to produce a smoke detector sensitivity report dated 03/26/25 for all smoke detectors. The report indicated 34 smoke detectors failed the sensitivity test. There was no documentation available to show the 34 failed smoke detectors have been replaced. Based on interview at 11:40 a.m., the Maintenance Director said he is waiting on a quote from the fire alarm system inspection vendor to replace the failed smoke detectors. He further said he was told by the vendor that the failed smoke detectors still work, but they were just out of the proper sensitivity range. This finding was reviewed with the Regional Vice President of Operations, Administrator, and Maintenance Director during the exit conference. 3.1-19(b)		monthly times 3 months to ensure all fire alarm inspections have been done as scheduled **The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 100 % 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.**	
K 0921 SS=F Bldg. 01	NFPA 101 Electrical Equipment - Testing and Maintenanc Based on record review, observation, and interview, the facility failed to conduct the	K 0921	**1) Immediate actions taken for those residents identified:**	05/16/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155820	A. BUILDING 01 B. WING	04/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
APERION CARE LINCOLN	1236 LINCOLN AVE EVANSVILLE, IN 47714

(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
	required maintenance and maintain complete documentation of inspections for Patient Care Related Electrical Equipment (PCREE). NFPA 99 2012 edition, sections 10.3 and 10.5 states the physical integrity, resistance, leakage current, and touch current tests for fixed and portable PCREE is performed as required in 10.3. Testing intervals are established with policies and protocols. All PCREE used in patient care rooms is tested in accordance with 10.3.5.4 or 10.3.6 before being put into service and after any repair or modification. Any system consisting of several electrical appliances demonstrates compliance with NFPA 99 as a complete system. Service manuals, instructions, and procedures provided by the manufacturer include information as required by 10.5.3.1.1 and are considered in the development of a program for electrical equipment maintenance. Electrical equipment instructions and maintenance manuals are readily available, and safety labels and condensed operating instructions on the appliance are legible. A record of electrical equipment tests, repairs, and modifications is maintained for a period of time to demonstrate compliance in accordance with the facility's policy. Personnel responsible for the testing, maintenance and use of electrical appliances receive continuous training. This deficient practice could affect all residents. Findings include: Based on record review on 04/30/25 at 11:50 a.m. with the Maintenance Director present, there was no documentation for the testing of PCREE, such as electric beds, nebulizers, oxygen concentrators, air pumps for air mattresses, and other electrical medical equipment. Based on interview at 11:50 a.m. during record review, the Maintenance Director said the facility had just become aware of		No Residents were affected by alleged deficient practice **2) How the facility identified other residents:** All residents have the potential to be affected by the alleged deficient practice. **3) Measures put into place/ System changes:** All PCREE items being tested, if items fail, they will be replaced, all equipment testing logged. Any new equipment will be tested. **4) How the corrective actions will be monitored:** Admin/Designee will complete weekly audit of 5 resident rooms for 4 weeks then every other week for 8 weeks then monthly times 3 months to ensure all PCREE items have been tested and logged. **The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 100 % 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.**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155820	A. BUILDING 01 B. WING	04/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
APERION CARE LINCOLN	1236 LINCOLN AVE EVANSVILLE, IN 47714

(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
	the requirement last week and has not tested and documented the PCREE items yet. Based on observations between 1:30 p.m. and 3:30 p.m. during a tour of the facility with the Maintenance Director it was revealed the facility provided PCREE such as electric beds, oxygen concentrators, air pumps for air mattresses, and other electrical medical equipment was present in the facility. This finding was reviewed with the Regional Vice President of Operations, Administrator, and Maintenance Director during the exit conference. 3.1-19(b)			