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	10/07/2022

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 a Post Survey Revisit (PSR) to the Recertification and State Licensure Survey completed on 7/12/22. This visit included a PSR to the State Residential Licensure Survey completed on 7/12/22. This visit was in conjunction with the Investigation of Complaint IN00387834 and IN00391902. Survey dates: October 4, 5, 6 and 7, 2022. Facility number: 012809 Provider number: 155799 AIM number: 201136580 Census Bed Type: SNF/NF: 49 SNF: 3 Residential: 13 Total: 65 Census Payor Type: Medicare: 3 Medicaid: 38 Other: 11 Total: 52 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed October 12. 2022	F 0000	Preparation and /or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.	
F 0584 SS=D Bldg. 00	483.10(i)(1)-(7) Safe/Clean/Comfortable/Homelike Environment §483.10(i) Safe Environment.			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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.

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	10/07/2022

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
	The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels.			

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	10/07/2022

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
	Based on observation and interview, the facility failed to ensure common areas and resident rooms were maintained in a clean and homelike manner for 1 of 2 nursing units (E hall). Findings include: During the initial tour of E hall, on 10/4/22 at 9:46 a.m., the following was observed: a. There were spots the size of softballs that were lighter than the carpet that extended from the entrance of E hall, passed the nurses station and down the hall to the exit door at the east end of E hall. b. In front of the nurses station were scattered dark grayish spots ranging from dime size to basketball size. With a large brown stain on the carpet at the entrance to the nurses station across from the medical records office. c. In room E142 was an area, the size of a recliner that was lighter than the rest of the carpet and extended near the bed. A residents name was on the outside of the door. During an interview with RN 22, on 10/5/22 at 10:17 a.m., he indicated the resident in E140 had passed away on Monday. d. At the entrance to room E140 there was a lighter area than the carpet, the size of a softball and in the room was a dark gray trail from the three drawer dresser below the television, that extended beside the resident's bed. e. An observation of E hall carpet, on 10/7/22 at 9:00 a.m., at the wall near room E129, there was a large dark brown area. LPN 12 indicated coffee	F 0584	1. Corrective actions which will be accomplished for those employees and residents found to be affected by the deficient practice: Carpets on E Hall, in front of elevator area and rooms E140 and resident rooms E140 and E142 were measured and flooring has been ordered and be replaced as soon as it is delivered. 2. How did the facility identify other residents having the potential to be affected by the same deficient practice: All residents have the potential to be affected by the alleged deficiency 3. The measures the facility will take or systems the facility will alter to ensure the problems will be corrected or will not recur: A floor tech has been hired and trained on the carpet cleaning machines. As housekeeping assess the carpets, during daily cleaning, they will alert floor tech of cleaning needs. Carpets will automatically be cleaned after each discharge. 4. Quality Assurance (QA) plans to monitor facility performance to make sure that corrections are achieved and are permanent: QA tools were created to ensure carpets are cleaned and in goo	10/20/2022

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	10/07/2022

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
	was spilled on the floor yesterday and the floor guy only worked certain days. During an interview with the Maintenance Supervisor, on 10/7/22 at 11:18 a.m., he indicated he did not handle the floor maintenance and the floor tech had parted ways with the facility. The housekeeping supervisor took over floor care and the laundry aide was doing the floors. During an interview with the ED (Executive Director), DON and the Regional Nurse Consultant, on 10/6/2022 at 10:53 a.m., the ED indicated the carpet was still an issue. The DON indicated two years ago D hall carpet was replaced, but the rest of the facility did not get replaced. During an interview with the ED, on 10/7/22 at 11:56 a.m., she indicated the Maintenance Supervisor had called a professional carpet cleaner to come in and clean the carpets. Housekeeping had mopped the floors but the professional carpet cleaners had been the only ones to clean the floors since the floor tech had left. They were hiring another floor tech and had just completed his background check. No further information was given prior to exiting the facility. This deficiency was cited on 8/12/22. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-19(f)(5)		condition. QA checks will be done on carpets of each discharged residents room and a carpet check list will be done by housekeepers during daily room cleans (Monday - Friday) for four (4) weeks. Then weekly for six (6) months or until an average of ninety percent (90%) compliance or greater is achieved for 3 consecutive months. QA committee will identify any areas that no longer benefit from cleaning schedule or patterns of traffic that affect the are and make recommendations to revise the plan of correction as indicated.	
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices			

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	10/07/2022

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
	§483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on interview and record review the facility failed to provided adequate supervision to prevent a cognitively impaired resident from exiting the building and property without supervision (Resident E) Findings include: The clinical record for Resident E was reviewed on 10/6/22 at 2:36 p.m.. Diagnoses included, but were not limited to, left side hemiparesis/hemiplegia related to history of cerebral vascular accident, history of falls, encephalopathy and diabetes. Review of a current Minimum Data Set (MDS), dated 9/23/22, indicated the resident was moderately cognitively impaired and ambulated with a cane. Review of an elopement assessment, dated 9/16/22, indicated the resident was not at risk for elopement. Review of a care plan for falls, dated 9/19/22, indicated the resident had encephalopathy that may effect the resident's safety awareness and/or judgment. Review of an elopement assessment, dated 10/1/22, indicated the resident was at risk for elopement.	F 0689	**F689** **Facility respectfully requests paper review/compliance for this citation.** **1. What corrective actions will be accomplished for those residents found to have been affected by the practice.** Resident was assessed at the time of the event and was found to have no injuries. Resident was placed on 1:1 observation from 10/1/22 at the time of the event until 10/2/22 when he was transported to a secured unit at one of our sister facilities. **2. How will other residents having the potential to be affected by the same practice and what corrective action will be taken:** Audit was conducted to identify those residents residing in the facility that are identified to be as risk for elopement. Identified residents had their care plans and interventions reviewed and updated, as necessary. **3. What measures will be put**	10/20/2022

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	10/07/2022

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
	Review of a police report, dated 10/1/22, indicated a missing persons call was received at 11:07 a.m. Police arrived at the facility at 11:26 a.m. and at 11:33 a.m. the resident had returned to the facility. During an interview, on 10/6/22 at 2:52 p.m., the Executive Director (ED) indicated the facility did not have security video. The ED indicated they believed another resident, currently discharged from the facility, opened the door for Resident E. During an interview, on 10/7/22 at 9:11 a.m., QMA 16 indicated on 10/1/22, she last saw the resident at approximately 7:30 a.m. The resident had been walking through the facility per his usual routine. During an interview, on 10/7/22 at 9:31 a.m., the Activity Director indicated she was contacted by Activity Aide 14 on the morning of 10/1/22 and informed that Resident E had eloped. The Activity Director instructed the Activity Aide to stop the activities and assist the staff with the search for the resident. The Activity Director then called the ED and informed her of the elopement. During the survey multiple attempts were made to contact Activity Aide 14 and were unsuccessful. During an interview, on 10/7/22 at 8:59 a.m., LPN 10 indicated around 8:30 a.m. on 10/1/22, the resident had been seen returning from breakfast. At approximately 10:30 a.m. a therapist asked if anyone knew where the resident was. Staff initiated a facility search and when the resident had not been located, LPN 10 called the police and reported the missing resident. LPN 10 then drove around the area and asked anyone if they had seen anyone fitting the description of the resident. An unknown person indicated they		**into place or what systematic changes you will make to ensure that the practice does not recur.** Facility Staff in-servicing initiated immediately per the Executive Director on Elopement policy on 10/1/22. All staff will receive re-education by DON/Designee relative to elopement prevention and procedures. Newly hired staff will be educated upon initial orientation, at least annually, and as needed on Elopement Protocol. Door Security checks will be completed weekly times 4 weeks, then bi-monthly for 6 months by Maintenance Supervisor/Designee. Door security checks remain on a preventative maintenance program to be completed by Maintenance Supervisor/Designee. Maintenance Supervisor/Designee will provide results of door security checks to the QAPI Committee monthly. Elopement Drill was completed on all shifts by Executive Director. Maintenance Supervisor/Designee will conduct elopement drills weekly to include all shifts for 4 weeks then bi-monthly to include all 3 shifts for 8 weeks. **4. How the corrective actions will be monitored to ensure the practice will not recur and what quality assurance**	

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	10/07/2022

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
	thought they had seen the resident at a local gas station located less than a mile from the facility. LPN 10 then went to the gas station and was told the resident had been there. LPN 10 then looked around the gas station and found the resident at a store located near the gas station. The resident indicated he had been out for a walk. LPN 10 was able to return the resident to the facility without incident. During an interview on 10/7/22 at 10:19 a.m., Receptionist 15, who was working on 10/1/22, indicated she arrived at the facility at 9:30 a.m., obtained a cup of coffee for the resident about 10:30 a.m. and had not seen the resident until he was returned to the facility at approximately 11:22 a.m.. Review of the investigative timeline indicated the resident was out of the facility, without supervision for approximately an hour. No further information was provided. This federal tag relates to Complaint IN00391902. 3.1-45(a)(2)		**program will be put into place.** Director of Nursing/Social Service Director/Designee will review Elopement Risk Assessment (ERA) UDAs on all newly admitted/readmitted residents daily, ongoing, during scheduled morning clinical meetings and weekly during comprehensive clinical review meetings; as well as monthly during the Quality Assurance/Performance Improvement with any identified concerns promptly addressed with the responsible individual(s). Results of the door security checks will be presented to the QAPI committee by the Maintenance Supervisor/Designee; results of the reviews of Elopement Binders will be presented to the QAPI committee by the SSD/Designee; staff response to elopement drills will be presented to the QAPI committee by the Maintenance Supervisor/Designee; and results of ERA reviews will be presented to the QAPI committee by the DON/SSD/Designee, all will be reviewed in Quality Assurance meeting monthly for 6 months or until 100% compliance is achieved for 3 consecutive months.	
F 9999 Bldg. 00				

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	10/07/2022

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
	Based on record review and interview, the facility failed to ensure annual resident rights and dementia training was completed for 1 of 5 employee files reviewed for required annual training (Human Resource Manager) and annual inservice audits were not completed for 3 of 3 months of audit tools reviewed for annual inservices (August, September and October). Findings include: Employee files were reviewed on 10/4/22 at 2:44 p.m. The Human Resource Manager lacked annual dementia and resident rights training. During an interview with the Executive Director, on 10/5/22 at 9:21 a.m., she indicated she was unable to find the plan of correction/audits. The Human Resource Manager was completing the audit tool for annual inservices and had quit last week so she tried to recreate it. The personnel in-service audit tool lacked audits for annual inservicing. During an interview with the Regional Nurse Consultant, on 10/6/22 at 11:43 a.m., she indicated they did not have a policy on annual inservices and they would follow the state regulations. This deficiency was cited on 7/12/22. The facility failed to implement a systemic plan of correction to prevent recurrence.	F 9999	1. Corrective actions which will be accomplished for those employees and residents found to be affected by the deficient practice: No residents where directly affected by this alleged deficient practice. 2. How did the facility identify other residents having the potential to be affected by the same deficient practice: All residents have the potential to be affected by the alleged deficient practice. Staff in-service records were reviewed to ensure all staff are up to date on the annual resident rights, dementia and abuse training. 3. The measures the facility will take or systems the facility will alter to ensure the problems will be corrected or will not recur: The Human Resource Director (HR)/designee and department managers are to ensure the staff has all their mandatory, yearly trainings done. The ED/designee shall audit all mandatory trainings weekly for one (1) month and then monthly for five (5) months. HR and managers will be re-educated iof issues and the employees shall be removed from the schedule until compliance is achieved. 4. Quality Assurance (QA) plans to monitor facility performance to	10/20/2022

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	10/07/2022

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
			make sure that corrections are achieved and are permanent: The audit will be reviewed in monthly QA meeting. This information will be presented to the QA committee monthly for six (6) months or until an average of ninety percent (90%) compliance or greater is achieved for three (3) consecutive months and make recommendations to revise the plan of correction as indicated.	
R 0000 Bldg. 00	This visit was for a Post Survey Revisit (PSR) to the State Residential Licensure Survey completed on 7/12/22. This visit included a PSR to the Recertification and State Licensure Survey completed on 7/12/22. This visit was in conjunction with a PSR to a Health Comparative Federal Monitoring Survey completed on 8/12/22. This visit was in conjunction with the Investigation of Complaint IN00387834 and IN00391902. Survey dates: October 4, 5, 6 and 7, 2022. Facility number: 012809 Residential Census: 13 Aperion Care Marion LLC was found to be in compliance with 410 IAC 16.2-5 in regard to the	R 0000	Preparation and /or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.	

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	10/07/2022

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
	PSR to the State Residential Licensure Survey. Quality review completed October 12, 2022			