STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155799	A. BUILDING _____ B. WING _____	R-C 08/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE MARION LLC	**614 WEST 14TH STREET MARION, IN 46953**

(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) COMPLETION DATE
{F 000}	INITIAL COMMENTS This visit was for a Post Survey Revisit (PSR) to the Investigation of Complaint IN00409757 completed on June 3, 2023. This visit was in conjunction with a PSR to the Recertification and State Licensure Survey completed on June 15, 2023. This visit was in conjunction with a PSR to the Investigation of Complaint IN00411202 completed on June 28, 2023. Complaint IN00409757 - Corrected. Complaint IN00411202 - Corrected. Survey dates: August 3 and August 4, 2023. Facility number: 12809 Provider number: 155799 AIM number: 201136580 Census Bed Type: SNF/NF: 41 SNF: 3 Total: 44 Census Payor Type: Medicare: 3 Medicaid: 27 Other: 14 Total: 44 Aperion Care Marion LLC was found to be in compliance with 42 CFR Part 483 Subpart B and 410 IAC 16.2-3.1 in regard to the PSR to the Investigation of Complaint IN00409757.	{F 000}		

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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 _____ B. WING _____	R-C 08/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE MARION LLC	**614 WEST 14TH STREET MARION, IN 46953**

(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) COMPLETION DATE
{F 000}	Continued From page 1 Quality review completed August 10, 2023.	{F 000}		