| 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 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 | {F 000} | | |

This visit was for a Post Survey Revisit (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.

This visit was in conjunction with a PSR to the Investigation of Complaint IN00409757 completed on June 3, 2023.

Complaint IN00411202 - Corrected.
Complaint IN00409757 - 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 Recertification and State Licensure Survey.

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| 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<br>Quality review completed August 10, 2023. | {F 000} | | |