| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155799 | A. Building<br>B. Wing | 02/03/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Aperion Care Marion LLC | 614 West 14th Street<br>Marion, IN 46953 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0839<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Employ staff that are licensed, certified, or registered in accordance with state laws.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40339<br><br>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)<br><br>Findings include:<br><br>During Employee Record Review, PN 2's nursing license was indicated as expired on [DATE] on the MyLicense.IN.gov website, accessed on [DATE] at 11:20 a.m.<br><br>PN 2 worked as a nurse, providing resident care, following the expiration of her licensure on the following dates:<br><br>[DATE], 8, 9, 10, 13, 14, 18, 19, 22, 23, 24, 27, and 28, 2024.<br><br>[DATE], 6, 7, 8, 11, 12, 16, 17, 20, 21, 22, 25, 26, 30, and 31, 2024.<br><br>[DATE], 5, 8, 9, 13, 14, 17, 18, 19, 22, 23, 27, 28, and 31, 2025.<br><br>During an interview on [DATE] 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 licensure was updated and valid. The facility followed state and federal regulations as the policy for licensure of resident care staff when indicated.<br><br>This citation relates to complaint IN00451756.<br><br>3XXX,d+[DATE](s) |

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.

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