

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155799	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/17/2025
NAME OF PROVIDER OR SUPPLIER  Aperion Care Marion LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  614 West 14th Street 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 0689  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.  (continued on next page)

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
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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on observation, interview, and record review, the facility failed to identify and ensure the resident environment remained free of potential hazards for 2 of 4 residents reviewed for smoking. (Resident B, Resident E) Findings include: 1. During an observation, on 7/16/25 at 12:14 p.m., Resident B held her cigarettes and lighter as she walked away from the designated smoking area. Resident B indicated she smoked independently and she was headed back to her room to store her cigarettes and smoking supplies. Resident B's clinical record was reviewed on 7/17/25 at 1:44 p.m. Diagnoses included hypertension (high blood pressure), chronic obstructive pulmonary disease (progressive lung disease that makes it hard to breathe), depression, and anxiety. An admission Minimum Data Set (MDS) assessment, dated 5/1/25, indicated Resident B was cognitively intact. Resident B's clinical record lacked an order for smoking. A smoking safety risk assessment, dated 4/28/25, indicated Resident B smoked daily and used cigarettes and a lighter. She did not have a history or currently present with unsafe storage of materials. The portion of the assessment that identified all smoking materials would be locked in the facility's designated area was not complete. The assessment indicated a smoking care plan was in place. Resident B's clinical record lacked a smoking care plan. 2. During an interview, on 7/17/25 at 10:15 a.m., Resident E indicated she vaped and pulled a red vape out of a black bag that was lying in bed next to her. Resident E's clinical record was reviewed on 7/17/25 at 1:44 p.m. Diagnoses included cerebral infarction (stroke), chronic obstructive pulmonary disease, and the need for assistance with personal care. A current order for Resident E indicated she could smoke as indicated for psychosocial and physical/medical necessity related to nicotine addiction (1/25/24). A quarterly Minimum Data Set assessment, dated 5/2/25, indicated Resident E had moderate cognitive impairment. She required supervision or touching assistance with eating. She required substantial/maximal assistance with oral hygiene, rolling left to right, and wheeling her wheelchair 50 feet. She was dependent for toileting, upper and lower body dressing, sitting to lying, lying to sitting, sit to stand, and chair/bed to chair transfers. Resident E's clinical record lacked a smoking care plan. A physician's progress note, dated 7/2/25, indicated Resident E was a current, some days, smoker and the tobacco type was vaping/e-cigarettes. A smoking safety risk assessment, dated 4/23/25, indicated Resident E did not currently smoke or use an electronic smoking device and she was not able to get to the designated area for smoking independently. All other questions on the assessment were unanswered. Resident E's electronic record contained her admission agreement. The agreement included a Resident and Visitor Smoking Policy Notification, which indicated there would be no smoking in any patient rooms and the authorized smoking area was the fire pit area. During an interview, on 7/17/25 at 2:54 p.m., LPN 2 indicated Resident E had a history of vaping and had not attended the supervised smoking breaks for two months. No residents were permitted to have smoking materials in their rooms. During an interview, on 7/17/25 at 3:20 p.m., Resident E indicated her family supplied her vaping devices. She vaped in her room, but not recently. She was aware it was against the rules. During an interview, on 7/17/25 at 3:54 p.m., the ADON indicated all smoking items and supplies for skilled nursing residents were kept at the front reception desk. No skilled nursing residents were permitted to keep smoking supplies in their rooms. A skilled nursing resident list of dependent and independent smokers, provided by the ADON on 7/16/25 at 10:46 AM, did not include Resident E. Resident B was identified as an independent smoker. A current policy titled Smoking Policy Acknowledgement Aperion Care Marion, undated, provided by the ADON on 7/16/25 at 10:46 a.m. indicated the following: .all residents are required to turn in all smoking materials to staff This citation relates to Complaint 1453272.3.1-45(a)(1)</p>		