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	09/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aperion Care Marion LLC	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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview and record review, the facility failed to ensure physician orders for blood pressure and heart rate parameters were followed when medications were administered for 2 of 3 residents reviewed for blood pressure medications. (Resident B and Resident D) Findings include: 1. Resident D's clinical record was reviewed on 9/9/25 at 11:11 a.m. Diagnoses included essential hypertension, hypertensive heart disease with heart failure, atherosclerotic heart disease of native coronary artery (plaque buildup in the artery) with unspecified angina pectoris (severe chest pain), and heart failure, unspecified. Physician orders included metoprolol tartrate (for blood pressure) 50 milligrams (mg) two times a day - hold for systolic blood pressure (SBP) less than 100 either/or heart rate (HR) less than 60 (started 4/16/25 and discontinued 8/9/25), metoprolol tartrate 50 mg two times a day - hold if SBP less than 100 or HR less than 50 (started 8/9/25), losartan potassium (for blood pressure) 100 mg daily - hold for SBP less than 110 or diastolic blood pressure (DBP) less than 60 (started 6/8/24), amlodipine besylate (for blood pressure) 10 mg daily - hold for SBP less than 100 or HR less than 60 (started 4/17/25), and hydralazine (for blood pressure) 25 mg every six hours as needed for SBP greater than 150 - administer one hour after routine blood pressure medication if SBP remains greater than 150 (started 12/5/24). An Annual Minimum Data Set (MDS) assessment, dated 5/22/25, indicated the resident was cognitively intact. The resident rejected care daily. He received opioid, diuretic, and antidepressant medications. A care plan for coronary artery disease related to lifestyle choices and smoking was initiated 5/22/24. Interventions included the following: Give all cardiac medications as ordered by the physician. Monitor and document side effect. Report adverse reactions to the physician as needed (5/22/24), Give medications for hypertension and document response to medication and any side effects (5/22/24), and Monitor blood pressure. Notify physician of any abnormal readings (5/22/24). A care plan for hypertension related to lifestyle choices and smoking was initiated on 5/22/24. Interventions included the following: Give anti-hypertensive medications as ordered. Monitor for side effects such as orthostatic hypotension and increased heart rate and effectiveness (5/22/24) and Medications as ordered (5/22/24). A current medication administration record for September 2025 indicated the following: On 9/1/25 at 7:00 a.m., the resident's heart rate was 47, and his blood pressure was 118/53. The resident received amlodipine besylate 10 mg, metoprolol tartrate 50 mg, and losartan potassium 100 mg. The resident's heart rate and/or blood pressure were not within the ordered parameters. On 9/3/25 at 7:00 a.m., the resident's heart rate was 48. The resident received amlodipine besylate 10 mg and metoprolol tartrate 50 mg. The resident's heart rate was not within the ordered parameters. On 9/5/25 at 8:00 p.m., the resident's blood pressure was 96/53. The resident received metoprolol tartrate 50 mg. The resident's blood pressure was not within the ordered parameters. On 9/6/25 at 7:00 a.m., the resident's heart rate was 50, and his blood pressure was 93/49. The resident received amlodipine besylate 10 mg, metoprolol tartrate 50 mg, and losartan potassium 100 mg. The resident's blood pressure and/or heart rate were not within the ordered parameters. On 9/9/25 at 7:00 a.m., the resident's heart rate was 54. The resident received amlodipine besylate 10 mg. The resident's heart rate was not within the ordered parameters. During an interview, on 9/9/25 at 3:41 p.m., RN 3 indicated when a medication had blood pressure and heart rate parameters, she obtained the blood pressure and heart rate. She administered the medication if the blood pressure and heart rate met the parameters. If the medication order was unclear, she would call the physician to get further instructions. 2. Resident B's clinical record was reviewed on 9/9/25 at 12:20 p.m. Diagnoses included atherosclerotic heart disease of native coronary artery with unstable angina pectoris, unspecified combined systolic (congestive) and diastolic (congestive) heart failure, and essential (primary) hypertension. Physician orders included midodrine 5 mg every eight hours as needed (PRN) for hypotension (low blood pressure) - administer for systolic blood pressure (SBP) less than 90 (started 3/17/25) and blood pressure monitoring three times a day for hypotension - administer PRN midodrine 5 mg for SBP less than 90. An annual Minimum Data Set (MDS) assessment, dated 8/2/25, indicated the resident was moderately cognitively impaired. No behaviors were marked. A care plan for coronary artery disease was initiated on 1/28/24. Interventions included give medications for hypertension and document response to medication and any side effects (1/28/24) and monitor blood pressure and notify physician of any abnormal readings (1/28/24). A medication administration record (MAR) for July 2025 indicated the following: On 7/1/25 at 3:00 p.m., the resident's blood pressure was 88/54. The MAR lacked an entry for the administration of midodrine on 7/1/25. On 7/11/25 at 7:00 a.m., the resident's blood pressure was 83/49. The MAR lacked an entry for the administration of midodrine on 7/11/25. On 7/19/25 at 7:00 a.m.