

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/08/2023  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>155572</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>08/03/2023</b>
NAME OF PROVIDER OR SUPPLIER  <b>APERION CARE DEMOTTE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>10352 N 600 E COUNTY LINE RD</b> <b>DEMOTTE, IN 46310</b>		
(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	<p><b>INITIAL COMMENTS</b></p> <p>This visit was for the Investigation of Nursing Home Complaints IN00411590, IN00412673, and IN00414333.</p> <p>This visit was in conjunction with a Post Survey Revisit (PSR) to the Investigation of Nursing Home Complaints IN00408033 and IN00409616 and Residential Complaint IN00405486 completed on 6/9/23.</p> <p>Complaint IN00408033 - Corrected.</p> <p>Complaint IN00409616 - Corrected.</p> <p>Complaint IN00405486 - Corrected</p> <p>Complaint IN00411590 - No deficiencies related to the allegations are cited.</p> <p>Complaint IN00412673 - No deficiencies related to the allegations are cited.</p> <p>Complaint IN00414333 - No deficiencies related to the allegations are cited.</p> <p>Survey dates: August 2 and 3, 2023</p> <p>Facility number: 000471 Provider number: 155572 AIM number: 100290390</p> <p>Census Bed Type: SNF/NF: 59 SNF: 5 Residential: 7 Total: 71</p>	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.

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F 000	Continued From page 1 Census Payor Type: Medicare: 1 Medicaid: 33 Other: 30 Total: 64  Aperion Care Demotte was found to be in compliance with 42 CFR Part 483 Subpart B and 410 IAC 16.2-3.1 in regard to the Investigation of Nursing Home Complaints IN00411590, IN00412673, and IN00414333.  Quality review completed on 8/4/23.	F 000			