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	08/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
APERION CARE MARION LLC	614 WEST 14TH STREET MARION, IN 46953

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 08/16/22 Facility Number: 012809 Provider Number: 155799 AIM Number: 200136580 At this Emergency Preparedness survey, Aperion Care Marion LLC was found in not compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has a capacity of 70 and had a census of 52 at the time of this survey. Quality Review completed on 08/17/22 The requirement at 42 CFR, Subpart 483.73 is NOT MET as evidenced by:	E 0000	This Plan of Correction is the center's allegation of compliance. Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provisions of federal and state law.	
E 0004 SS=F Bldg. --	403.748(a), 416.54(a), 418.113(a), 441.184(a), 482.15(a), 483.475(a), 483.73(a), 484.102(a), 485.625(a), 485.68(a), 485.727(a), 485.920(a), 486.360(a), 491.12(a), 494.62(a) Develop EP Plan, Review and Update Annually §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a).			

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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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	The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. .			
	Based on record review and interview, the facility	E 0004	1. Corrective actions which will be	08/22/2022

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	failed to review and update the Emergency Preparedness Plan (EPP) at least annually in accordance with 42 CFR 483.73(a). This deficient practice could affect all occupants. Findings include: Based on records review with the Maintenance Director on 08/16/22 at 10:41 a.m., the EEP had a review date of 06/16/21, no other documentation could be found to show the EPP was reviewed and updated within the last year. Based on an interview during records review, the Maintenance Director stated the documentation to show the EEP has been reviewed or updated within the last year could not be found. This finding was reviewed with the Maintenance Director during the exit conference.		accomplished for those employees and residents found to be affected by the deficient practice: All residents have the potential to be affected by this alleged deficiency practice of the Emergency Preparedness Plan (EPP) of not being updated. 2. How will the facility identify other residents having the potential to be affected by the same deficient practice: All residents, staff and visitors could have the potential to be affected by the alleged deficiency. EPP book was reviewed and updated. 3. The measures the facility will take or systems the facility will alter to ensure the problems will be corrected or will not recur: Maintenance Director/Designee has updated the EPP and has added a task to the TELS system for 2023 review and update. 4. Quality Assurance (QA) plans to monitor facility performance to make sure that corrections are achieved and are permanent: A QA tool was created to monitor the yearly updates and review of the EPP. This tool is placed in	

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			the May section of the QA book. it will be reviewed in May of every year or until an average of ninety percent (90%) compliance or greater is achieved for three (3) years. QA committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	
E 0013 SS=F Bldg. --	403.748(b), 416.54(b), 418.113(b), 441.184(b), 482.15(b), 483.475(b), 483.73(b), 484.102(b), 485.625(b), 485.68(b), 485.727(b), 485.920(b), 486.360(b), 491.12(b), 494.62(b) Development of EP Policies and Procedures §403.748(b), §416.54(b), §418.113(b), §441.184(b), §460.84(b), §482.15(b), §483.73(b), §483.475(b), §484.102(b), §485.68(b), §485.625(b), §485.727(b), §485.920(b), §486.360(b), §491.12(b), §494.62(b). (b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(b):] Policies and procedures. The LTC facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at			

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	paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. *Additional Requirements for PACE and ESRD Facilities: *[For PACE at §460.84(b):] Policies and procedures. The PACE organization must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must address management of medical and nonmedical emergencies, including, but not limited to: Fire; equipment, power, or water failure; care-related emergencies; and natural disasters likely to threaten the health or safety of the participants, staff, or the public. The policies and procedures must be reviewed and updated at least every 2 years. *[For ESRD Facilities at §494.62(b):] Policies and procedures. The dialysis facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. These emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters			

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	likely to occur in the facility's geographic area. Based on record review and interview, the facility failed to review and update the Emergency Preparedness Plan's (EPP) Policies and Procedures at least annually in accordance with 42 CFR 483.73(a). This deficient practice could affect all occupants. Findings include: Based on records review with the Maintenance Director on 08/16/22 at 10:41 a.m., the EEP had a review date of 06/16/21, no other documentation could be found to show the EPP Policies and Procedures were reviewed and updated within the last year. Based on an interview during records review, the Maintenance Director stated the documentation to show the EEP Policies and Procedures have been reviewed or updated within the last year could not be found. This finding was reviewed with the Maintenance Director during the exit conference.	E 0013	1. Corrective actions which will be accomplished for those employees and residents found to be affected by the deficient practice: All residents have the potential to be affected by this alleged deficiency practice of the Emergency Preparedness Plan (EPP) of not being updated. 2. How will the facility identify other residents having the potential to be affected by the same deficient practice: All residents, staff and visitors could have the potential to be affected by the alleged deficiency. EPP book was reviewed and updated. 3. The measures the facility will take or systems the facility will alter to ensure the problems will be corrected or will not recur: Maintenance Director/Designee has updated the EPPand has added a task to the TELS system for 2023 review and update. 4. Quality Assurance (QA) plans to monitor facility performance to make sure that corrections are achieved and are permanent:	08/22/2022

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			A QA tool was created to monitor the yearly updates and review of the EPP. This tool is placed in the May section of the QA book. it will be reviewed in May of every year or until an average of ninety percent (90%) compliance or greater is achieved for three (3) years. QA committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	
E 0015 SS=C Bldg. --	403.748(b)(1), 418.113(b)(6)(iii), 441.184(b)(1), 482.15(b)(1), 483.475(b)(1), 483.73(b)(1), 485.625(b)(1) Subsistence Needs for Staff and Patients §403.748(b)(1), §418.113(b)(6)(iii), §441.184(b)(1), §460.84(b)(1), §482.15(b)(1), §483.73(b)(1), §483.475(b)(1), §485.625(b)(1) [(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following: (1) The provision of subsistence needs for staff and patients whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical and pharmaceutical supplies			

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	(ii) Alternate sources of energy to maintain the following: (A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (B) Emergency lighting. (C) Fire detection, extinguishing, and alarm systems. (D) Sewage and waste disposal. *[For Inpatient Hospice at §418.113(b)(6)(iii):] Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following: (iii) The provision of subsistence needs for hospice employees and patients, whether they evacuate or shelter in place, include, but are not limited to the following: (A) Food, water, medical, and pharmaceutical supplies. (B) Alternate sources of energy to maintain the following: (1) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (2) Emergency lighting. (3) Fire detection, extinguishing, and alarm systems. (C) Sewage and waste disposal.			
	Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include at a minimum, (1) The provision of subsistence needs for staff and residents, whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical, and pharmaceutical supplies. (ii) Alternate sources of energy to maintain - (A) Temperatures to protect resident	E 0015	1. Corrective actions which will be accomplished for those employees and residents found to be affected by the deficient practice: All residents have the potential to be affected by this alleged deficiency practice of the	08/22/2022

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	health and safety and for the safe and sanitary storage of provisions; (B) Emergency lighting; (C) Fire detection, extinguishing, and alarm systems; and (D) Sewage and waste disposal in accordance with 42 CFR 483.73(b)(1). This deficient practice could affect all occupants. Findings include: Based on records review with the Maintenance Director on 08/16/22 at 10:50 a.m., the subsistence needs documentation for the emergency preparedness program was incomplete. Documentation for sewage and waste outage policy was not available for review. Based on interview at the time of records review, the Maintenance Director stated the sewage and waste outage policy could not be found. This finding was reviewed with the Maintenance Director during the exit conference.		Emergency Preparedness Plan (EPP) of not being updated. 2. How will the facility identify other residents having the potential to be affected by the same deficient practice: All residents, staff and visitors could have the potential to be affected by the alleged deficiency. EPP book was reviewed and updated including the policy for a sewage and waste outage policy. 3. The measures the facility will take or systems the facility will alter to ensure the problems will be corrected or will not recur: Maintenance Director/Designee has updated the EPP and has added a task to the TELS system for 2023 review and update. 4. Quality Assurance (QA) plans to monitor facility performance to make sure that corrections are achieved and are permanent: A QA tool was created to monitor the yearly updates and review of the EPP. The review will include going over the sewage and waste outage policy. This tool is placed in the May section of the QA book. it will be reviewed in May of every year or until an average of ninety percent (90%) compliance or greater is achieved for three (3)	

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			years. QA committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	
E 0024 SS=C Bldg. --	403.748(b)(6), 416.54(b)(5), 418.113(b)(4), 441.184(b)(6), 482.15(b)(6), 483.475(b)(6), 483.73(b)(6), 484.102(b)(5), 485.625(b)(6), 485.68(b)(4), 485.727(b)(4), 485.920(b)(5), 491.12(b)(4), 494.62(b)(5) Policies/Procedures-Volunteers and Staffing §403.748(b)(6), §416.54(b)(5), §418.113(b)(4), §441.184(b)(6), §460.84(b)(7), §482.15(b)(6), §483.73(b)(6), §483.475(b)(6), §484.102(b)(5), §485.68(b)(4), §485.625(b)(6), §485.727(b)(4), §485.920(b)(5), §491.12(b)(4), §494.62(b)(5). [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] (6) [or (4), (5), or (7) as noted above] The use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency. *[For RNHCIs at §403.748(b):] Policies and procedures. (6) The use of volunteers in an			

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	emergency and other emergency staffing strategies to address surge needs during an emergency. *[For Hospice at §418.113(b):] Policies and procedures. (4) The use of hospice employees in an emergency and other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency. Based on record review and interview, the facility failed to ensure Emergency Preparedness Plan (EPP) includes the use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State or Federally designated health care professionals to address surge needs during an emergency in accordance with 42 CFR 483.73(b)(6). This deficient practice could affect all occupants. Findings include: Based on records review with the Maintenance Director on 08/16/22 at 10:51 a.m., the provided EPP did not address the use of volunteers in an emergency. Based on interview at the time of records review, the Maintenance Director stated a policy on the use of volunteers in an emergency could not be found. This finding was reviewed with the Maintenance Director during the exit conference.	E 0024	1. Corrective actions which will be accomplished for those employees and residents found to be affected by the deficient practice: All residents have the potential to be affected by this alleged deficiency practice of the Emergency Preparedness Plan (EPP) of not being updated. 2. How will the facility identify other residents having the potential to be affected by the same deficient practice: All residents, staff and visitors could have the potential to be affected by the alleged deficiency. EPP book was reviewed and updated, a policy for staffing, in case of an emergency is in place, however volunteers are not used or included in said policy. 3. The measures the facility will take or systems the facility will	08/22/2022

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			alter to ensure the problems will be corrected or will not recur: Maintenance Director/Designee has updated the EPP and has added a task to the TELS system for 2023 review and update. 4. Quality Assurance (QA) plans to monitor facility performance to make sure that corrections are achieved and are permanent: A QA tool was created to monitor the yearly updates and review of the EPP, including the policy for staffing in case of an emergency. This tool is placed in the May section of the QA book. it will be reviewed in May of every year or until an average of ninety percent (90%) compliance or greater is achieved for three (3) years. QA committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	
E 0029 SS=F Bldg. --	403.748(c), 416.54(c), 418.113(c), 441.184(c), 482.15(c), 483.475(c), 483.73(c), 484.102(c), 485.625(c), 485.68(c), 485.727(c), 485.920(c), 486.360(c), 491.12(c), 494.62(c) Development of Communication Plan §403.748(c), §416.54(c), §418.113(c), §441.184(c), §460.84(c), §482.15(c), §483.73(c), §483.475(c), §484.102(c), §485.68(c), §485.625(c), §485.727(c), §485.920(c), §486.360(c), §491.12(c), §494.62(c).			

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	(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. Based on record review and interview, the facility failed to review and update the Emergency Preparedness Plan's (EPP) Communication Plan at least annually in accordance with 42 CFR 483.73(a). This deficient practice could affect all occupants. Findings include: Based on records review with the Maintenance Director on 08/16/22 at 10:41 a.m., the EEP had a review date of 06/16/21, no other documentation could be found to show the EPP Communication Plan was reviewed and updated within the last year. Based on an interview during records review, the Maintenance Director stated the documentation to show the EEP Communication Plan has been reviewed or updated within the last year could not be found. This finding was reviewed with the Maintenance Director during the exit conference.	E 0029	1. Corrective actions which will be accomplished for those employees and residents found to be affected by the deficient practice: All residents have the potential to be affected by this alleged deficiency practice of the Emergency Preparedness Plan (EPP) of not being updated. 2. How will the facility identify other residents having the potential to be affected by the same deficient practice: All residents, staff and visitors could have the potential to be affected by the alleged deficiency. EPP book was reviewed and updated, including the Communication plan. 3. The measures the facility will take or systems the facility will alter to ensure the problems will be corrected or will not recur: Maintenance Director/Designee has updated the EPP and has added a task to the TELS system for 2023 review and update.	08/22/2022

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	08/16/2022

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			4. Quality Assurance (QA) plans to monitor facility performance to make sure that corrections are achieved and are permanent: A QA tool was created to monitor the yearly updates and review of the EPP, including the communication plan. This tool is placed in the May section of the QA book. it will be reviewed in May of every year or until an average of ninety percent (90%) compliance or greater is achieved for three (3) years. QA committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	
E 0031 SS=C Bldg. --	403.748(c)(2), 416.54(c)(2), 418.113(c)(2), 441.184(c)(2), 482.15(c)(2), 483.475(c)(2), 483.73(c)(2), 484.102(c)(2), 485.625(c)(2), 485.68(c)(2), 485.727(c)(2), 485.920(c)(2), 486.360(c)(2), 491.12(c)(2), 494.62(c)(2) Emergency Officials Contact Information §403.748(c)(2), §416.54(c)(2), §418.113(c)(2), §441.184(c)(2), §460.84(c)(2), §482.15(c)(2), §483.73(c)(2), §483.475(c)(2), §484.102(c)(2), §485.68(c)(2), §485.625(c)(2), §485.727(c)(2), §485.920(c)(2), §486.360(c)(2), §491.12(c)(2), §494.62(c)(2). [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. The communication plan must			

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	155799	A. BUILDING -- B. WING	08/16/2022

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	include all of the following: (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) Other sources of assistance. *[For LTC Facilities at §483.73(c):] (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) The State Licensing and Certification Agency. (iii) The Office of the State Long-Term Care Ombudsman. (iv) Other sources of assistance. *[For ICF/IIDs at §483.475(c):] (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) Other sources of assistance. (iii) The State Licensing and Certification Agency. (iv) The State Protection and Advocacy Agency.			
	Based on record review and interview, the facility failed to ensure the emergency preparedness communication plan includes (2) Contact information for the following: (i) Federal, State, tribal, regional, or local emergency preparedness staff (ii) The State Licensing and Certification Agency (iii) The Office of the State Long-Term Care Ombudsman (iv) Other sources of assistance in accordance with 42 CFR 483.73(c) (2). This deficient practice could affect all occupants. Findings include: Based on record review with the Maintenance	E 0031	1. Corrective actions which will be accomplished for those employees and residents found to be affected by the deficient practice: All residents have the potential to be affected by this alleged deficiency practice of the Emergency Preparedness Plan (EPP) of not being updated. 2. How will the facility identify other residents having the	08/22/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
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	Director on 08/16/22 at 10:43 a.m., the emergency preparedness communication plan for Federal, State, Tribal emergency preparedness staff contact information was not available for review. This included The State Licensing and Certification Agency, The Office of the State Long-Term Care Ombudsman, and other sources of assistance. Based on interview at the time of record review, the Maintenance Director stated the facility does have the contact info but did not know the location of the contact information for Federal, State, Tribal agencies.		potential to be affected by the same deficient practice: All residents, staff and visitors could have the potential to be affected by the alleged deficiency. EPP book was reviewed and updated. 3. The measures the facility will take or systems the facility will alter to ensure the problems will be corrected or will not recur: Maintenance Director/Designee has updated the EPP official's contact information and has added a task to the TELS system for 2023 review and update. 4. Quality Assurance (QA) plans to monitor facility performance to make sure that corrections are achieved and are permanent: A QA tool was created to monitor the yearly updates and review of the EPP including the official's contact information. This tool is placed in the May section of the QA book. it will be reviewed in May of every year or until an average of ninety percent (90%) compliance or greater is achieved for three (3) years. QA committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	

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E 0036 SS=F Bldg. --	403.748(d), 416.54(d), 418.113(d), 441.184(d), 482.15(d), 483.475(d), 483.73(d), 484.102(d), 485.625(d), 485.68(d), 485.727(d), 485.920(d), 486.360(d), 491.12(d), 494.62(d) EP Training and Testing §403.748(d), §416.54(d), §418.113(d), §441.184(d), §460.84(d), §482.15(d), §483.73(d), §483.475(d), §484.102(d), §485.68(d), §485.625(d), §485.727(d), §485.920(d), §486.360(d), §491.12(d), §494.62(d). *[For RNCHIs at §403.748, ASCs at §416.54, Hospice at §418.113, PRTFs at §441.184, PACE at §460.84, Hospitals at §482.15, HHAs at §484.102, CORFs at §485.68, CAHs at §486.625, "Organizations" under 485.727, CMHCs at §485.920, OPOs at §486.360, and RHC/FHQs at §491.12:] (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(d):] (d) Training and testing. The LTC facility must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the			

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	communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. *[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(i). *[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be evaluated and updated at every 2 years.			
	Based on record review and interview, the facility failed to review and update the Emergency Preparedness Plan's (EPP) Training and Testing Plan at least annually in accordance with 42 CFR 483.73(a). This deficient practice could affect all occupants.	E 0036	1. Corrective actions which will be accomplished for those employees and residents found to be affected by the deficient practice: All residents have the potential to	08/22/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
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	Findings include: Based on records review with the Maintenance Director on 08/16/22 at 10:41 a.m., the EEP had a review date of 06/16/21, no other documentation could be found to show the EPP Training and Testing Plan was reviewed and updated within the last year. Based on an interview during records review, the Maintenance Director stated the documentation to show the EEP Training and Testing Plan has been reviewed or updated within the last year could not be found. This finding was reviewed with the Maintenance Director during the exit conference.		be affected by this alleged deficiency practice of the Emergency Preparedness Plan (EPP) of not being updated. 2. How will the facility identify other residents having the potential to be affected by the same deficient practice: All residents, staff and visitors could have the potential to be affected by the alleged deficiency. EPP book was reviewed and updated. 3. The measures the facility will take or systems the facility will alter to ensure the problems will be corrected or will not recur: Maintenance Director/Designee has updated the EPP training and testing plan and has added a task to the TELS system for 2023 review and update. 4. Quality Assurance (QA) plans to monitor facility performance to make sure that corrections are achieved and are permanent: A QA tool was created to monitor the yearly updates and review of the EPP including the training and testing plan This tool is placed in the May section of the QA book. it will be reviewed in May of every year or until an average of ninety percent (90%)	

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			compliance or greater is achieved for three (3) years. QA committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	
E 0041 SS=C Bldg. --	482.15(e), 483.73(e), 485.625(e) Hospital CAH and LTC Emergency Power §482.15(e) Condition for Participation: (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section. §483.73(e), §485.625(e) (e) Emergency and standby power systems. The [LTC facility and the CAH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.625(e)(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2) Emergency generator inspection and testing.			

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	The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000.			

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	(i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009..			
	Based on records review and interview, the facility failed to implement the emergency power system requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code in accordance with 42 CFR 483.73(e)(2). This deficient practice could affect all occupants. Findings include: Based on records review with the Maintenance Director on 08/16/22 at 11:02 a.m., the generator lacked the monthly load testing and weekly inspections from 09/1/21 to 03/31/22 required by LSC and NFPA 110. Based on interview at the	E 0041	1. Corrective actions which will be accomplished for those employees and residents found to be affected by the deficient practice: All residents have the potential to be affected by this alleged deficiency practice of the lack of the generator monthly load testing and weekly inspections from 09/01/2021-03/31/2022. 2. How will the facility identify	08/22/2022

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	08/16/2022

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	time of record review, the Maintenance Director stated the generator was missing required testing due to the lack of a Maintenance person during the forementioned time frame. The findings were reviewed with the Maintenance Director at the exit conference.		other residents having the potential to be affected by the same deficient practice: All residents, staff and visitors could have the potential to be affected by the alleged deficiency of missing generator testing and inspections. 3. The measures the facility will take or systems the facility will alter to ensure the problems will be corrected or will not recur: Maintenance Director/Designee has been doing the testing and inspections of the generator and has added a task to the TELS system for both. 4. Quality Assurance (QA) plans to monitor facility performance to make sure that corrections are achieved and are permanent: A QA tool was created to monitor the monthly load testing and weekly inspections. It will be reviewed monthly for six (6) months or until an average of ninety percent (90%) compliance or greater is achieved for three (3) months. QA committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	

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	155799	A. BUILDING 01 B. WING	08/16/2022

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K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 08/16/22 Facility Number: 012809 Provider Number: 155799 AIM Number: 200136580 At this Life Safety Code survey, Aperion Care Marion LLC was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility with a partial basement was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in corridors, areas open to the corridors and resident rooms. The facility has a capacity of 70 and had a census of 52 at the time of this survey. All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered. Quality Review completed on 08/17/22	K 0000	This Plan of Correction is the center's allegation of compliance. Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provisions of federal and state law.	
K 0293 SS=E Bldg. 01	NFPA 101 Exit Signage Exit Signage			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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	2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) Based on observation and interview, the facility failed to ensure 1 of 2 therapy doors to the outside of the facility were not mistaken as a facility exit. LSC 7.10.8.3.1 states any door, passage, or stairway that is neither an exit nor a way of exit access and that is located or arranged so that it is likely to be mistaken for an exit shall be identified by a sign that reads as follows: NO EXIT. The NO EXIT sign shall have the word NO in letters 2 inches high, with a stroke width of 3/8ths inch, and the word EXIT below the word NO, unless such sign is an approved existing sign. This deficient practice could affect 8 residents in therapy. Findings include: Based on observation with the Maintenance Director on 08/16/22 at 12:20 p.m., in therapy, the side door to the outside was not an exit door and the door was not posted with a "NO EXIT" sign. Based on interview at the time of the observations, the Maintenance Director stated the therapy side door is not an exit and the door did not have a "NO EXIT" sign posted. The findings were reviewed with the Maintenance Director at the exit conference. 3.1-19(b)	K 0293	1. Corrective actions which will be accomplished for those employees and residents found to be affected by the deficient practice: All residents have the potential to be affected by this alleged deficiency practice of the lack of a "NO EXIT" sign for door eight (8). 2. How will the facility identify other residents having the potential to be affected by the same deficient practice: All residents, staff and visitors could have the potential to be affected by the alleged deficiency of the lack of a "NO EXIT" sign for door eight (8). 3. The measures the facility will take or systems the facility will alter to ensure the problems will be corrected or will not recur: Maintenance Director/Designee has hung a "NO EXIT" sign on door eight (8).	08/22/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155799	A. BUILDING 01 B. WING	08/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
APERION CARE MARION LLC	614 WEST 14TH STREET MARION, IN 46953

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			4. Quality Assurance (QA) plans to monitor facility performance to make sure that corrections are achieved and are permanent: A QA tool was created to monitor and ensure that all doors in facility have proper signage on them. It will be reviewed monthly for six (6)months or until an average of ninety percent (90%) compliance or greater is achieved for three (3) months. QA committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	
K 0341 SS=C Bldg. 01	NFPA 101 Fire Alarm System - Installation Fire Alarm System - Installation A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8 Based on observation and interview, the facility failed to ensure 1 of 1 fire alarm systems was continuously in proper operating condition. NFPA 72, National Fire Alarm and Signaling Code,	K 0341	1. Corrective actions which will be accomplished for those employees and residents found to be affected by the deficient	08/22/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155799	A. BUILDING 01 B. WING	08/16/2022

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	2010 Edition, Section 14.2.1.2.2 states system defects and malfunctions shall be corrected. This deficient practice could affect all residents, staff and visitors. Findings include: Based on observation of the fire alarm control panel with the Maintenance Director on 08/16/22 at 11:15 a.m., the time on the display of the fire alarm control panel indicated the time to be 10:20 a.m. when checked at 11:15 a.m. Based on interview at the time of observation, the Maintenance Director agreed the fire alarm control panel had the wrong time and will need to be changed. The finding was reviewed with the Maintenance Director during the exit conference. 3.1-19(b)		practice: All residents have the potential to be affected by this alleged deficiency practice of the fire alarm panel. 2. How will the facility identify other residents having the potential to be affected by the same deficient practice: All residents, staff and visitors could have the potential to be affected by the alleged deficiency of the fire alarm control panel time not being correct. 3. The measures the facility will take or systems the facility will alter to ensure the problems will be corrected or will not recur: Maintenance Director/Designee has had the the issue with the incorrect fire control panel time corrected. 4. Quality Assurance (QA) plans to monitor facility performance to make sure that corrections are achieved and are permanent: A QA tool was created to monitor and ensure that the time on the fire control panel is correct. It will be reviewed monthly for six (6)months or until an average of ninety percent (90%) compliance or greater is achieved for three (3)	

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	155799	A. BUILDING 01 B. WING	08/16/2022

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			months. QA committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	
K 0521 SS=F Bldg. 01	NFPA 101 HVAC HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 Based on record review, observation, and interview; the facility failed to ensure 1 of 1 fire damper systems were inspected and provided necessary maintenance after the first year after instillation and at least every four years in accordance with NFPA 90A. LSC 9.2.1 requires heating, ventilating and air conditioning (HVAC) ductwork and related equipment shall be in accordance with NFPA 90A, Standard for the Installation of Air-Conditioning and Ventilating Systems. NFPA 90A, 2012 Edition, Section 5.4.8.1 states fire dampers shall be maintained in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. NFPA 80, 2010 Edition, Section 19.4.1 states each damper shall be tested and inspected 1 year after installation. Section 19.4.1.1 states the test and inspection frequency shall be every 4 years except for hospitals where the frequency is every 6 years. If the damper is equipped with a fusible link, the link shall be removed for testing to ensure full closure and lock-in-place if so equipped. The damper shall not be blocked from closure in any way. All inspections and testing shall be documented, indicating the location of the fire damper, date of inspection, name of inspector and	K 0521	1. Corrective actions which will be accomplished for those employees and residents found to be affected by the deficient practice: All residents have the potential to be affected by this alleged deficiency practice of the lack of the fire damper system inspection and testing. 2. How will the facility identify other residents having the potential to be affected by the same deficient practice: All residents, staff and visitors could have the potential to be affected by the alleged deficiency of the lack of the fire damper system being inspected and tested every 4 years. 3. The measures the facility will take or systems the facility will	08/22/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155799	A. BUILDING 01 B. WING	08/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	deficiencies discovered. The documentation shall have a space to indicate when and how the deficiencies were corrected. This deficient practice could affect all residents. Findings include: Based on records review with the Maintenance Director on 08/16/22 at 10:50 a.m., no documentation was provided to show if the building's smoke/fire dampers have been inspected. Based on observation with the Maintenance Director between 12:15 a.m. and 1:00 p.m., there were smoke/fire dampers in the duct work. Based on interview at the time of records review and observations, the Maintenance Director stated the damper inspection could not be found and did not know the last time the dampers were inspected. The findings were reviewed with the Maintenance Director at the exit conference. 3.1-19(b)		alter to ensure the problems will be corrected or will not recur: Maintenance Director/Designee has scheduled an inspection and testing of the fire damper system and for every 4 years hereafter. 4. Quality Assurance (QA) plans to monitor facility performance to make sure that corrections are achieved and are permanent: A QA tool was created to monitor and ensure that the time on the fire damper system is inspected and tested every 4 years. QA committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	
K 0531 SS=E Bldg. 01	NFPA 101 Elevators Elevators 2012 EXISTING Elevators comply with the provision of 9.4. Elevators are inspected and tested as specified in ASME A17.1, Safety Code for Elevators and Escalators. Firefighter's Service is operated monthly with a written record. Existing elevators conform to ASME/ANSI A17.3, Safety Code for Existing Elevators and Escalators. All existing elevators, having a travel distance of 25 feet or more above or below the level that best serves the needs of			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
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	emergency personnel for firefighting purposes, conform with Firefighter's Service Requirements of ASME/ANSI A17.3. (Includes firefighter's service Phase I key recall and smoke detector automatic recall, firefighter's service Phase II emergency in-car key operation, machine room smoke detectors, and elevator lobby smoke detectors.) 19.5.3, 9.4.2, 9.4.3 Based on record review and interview, the facility failed to maintain testing of 1 of 1 staff elevator firefighter recall in accordance with 9.4.6, Elevator Testing. LSC 9.4.6.2 states that all elevators with fire fighters' emergency operations in accordance with 9.4.3 shall be subject to a monthly operation with a written record of the findings made and kept on the premises as required by ASME A17.1/CSA B44, Safety Code for Elevators and Escalators. This deficient practice would affect staff that use the elevator. Findings include: Based on record review with the Maintenance Director on 08/16/22 at 10:53 a.m., the monthly testing for the elevator firefighter recall for the staff elevator was missing from September 2021 to March 2022. Based on interview at the time of record review, the Maintenance Director stated the missing monthly tests were missing due to no Maintenance Director during that time. The findings were reviewed with the Maintenance Director at the exit conference. 3.1-19(b)	K 0531	1. Corrective actions which will be accomplished for those employees and residents found to be affected by the deficient practice: All residents have the potential to be affected by this alleged deficiency practice of the fire alarm panel. 2. How will the facility identify other residents having the potential to be affected by the same deficient practice: All residents, staff and visitors could have the potential to be affected by the alleged deficiency of missing monthly testing for elevator firefighter recall for the staff elevator from September 2021- March 2022. 3. The measures the facility will take or systems the facility will alter to ensure the problems will be corrected or will not recur: Maintenance Director/Designee	08/22/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155799	A. BUILDING 01 B. WING	08/16/2022

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			has been completing the monthly testing on the elevator firefighter recall since April 2022. 4. Quality Assurance (QA) plans to monitor facility performance to make sure that corrections are achieved and are permanent: A QA tool was created to monitor and assure that the monthly testing for the elevator firefighter recall is done. It will be reviewed monthly for six (6)months or until an average of ninety percent (90%) compliance or greater is achieved for three (3) months. QA committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	
K 0741 SS=E Bldg. 01	NFPA 101 Smoking Regulations Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits			

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	smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4 Based on observation and interview; the facility failed to ensure combustible gases were not stored in 1 of 3 smoking areas. This deficient practice could affect 10 residents using the resident smoking area Findings include: Based on observation with the Maintenance Director on 08/16/22 at 12:10 p.m., the resident smoking area had a propane tank sitting inside the designated smoking area. Based on interview at the time of observation, the Maintenance Director stated the tank is used for the grill and moved the tank from the smoking area. The findings were reviewed with the Maintenance Director at the exit conference. 3.1-19(b)	K 0741	1. Corrective actions which will be accomplished for those employees and residents found to be affected by the deficient practice: All residents have the potential to be affected by this alleged deficiency practice of the propane tank sitting inside the designated smoking area. 2. How will the facility identify other residents having the potential to be affected by the same deficient practice: All residents, staff and visitors could have the potential to be affected by the alleged deficiency of a propane tank sitting inside the designated smoking area. 3. The measures the facility will take or systems the facility will alter to ensure the problems will	08/22/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155799	A. BUILDING 01 B. WING	08/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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			be corrected or will not recur: Maintenance Director moved the propane tank as soon as it was brought to his attention. 4. Quality Assurance (QA) plans to monitor facility performance to make sure that corrections are achieved and are permanent: A QA tool was created to monitor and assure that the the propane tank is stored in a none smoking area. It will be reviewed monthly for six (6)months or until an average of ninety percent (90%) compliance or greater is achieved for three (3) months. QA committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	
K 0918 SS=F Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a			

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	155799	A. BUILDING 01 B. WING	08/16/2022

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	year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)			
	Based on record review and interview, the facility failed to maintain a complete written record of monthly generator load testing for 7 of 12 months and weekly inspection for 29 of 52 weeks. Chapter 6.4.4.1.1.4(a) of 2012 NFPA 99 requires monthly testing of the generator serving the emergency electrical system to be in accordance with NFPA 110, the Standard for Emergency and Standby Powers Systems, Chapter 8. NFPA 110 8.4.2 requires diesel generator sets in service to be exercised at least once monthly, for a minimum of 30 minutes. Section 8.4.1 requires an Emergency Power Supply System (EPSS) including all appurtenant components, shall be inspected weekly and exercised monthly. Chapter 6.4.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available	K 0918	1. Corrective actions which will be accomplished for those employees and residents found to be affected by the deficient practice: All residents have the potential to be affected by this alleged deficiency practice of the lack of written record of monthly generator load testing and weekly inspection from 09/01/2021-03/31/2022 2. How will the facility identify other residents having the potential to be affected by the same deficient practice:	08/22/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155799	A. BUILDING 01 B. WING	08/16/2022

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	for inspection by the authority having jurisdiction. This deficient practice could affect all occupants. Findings include: Based on records review with the Maintenance Director on 08/16/22 at 10:30 a.m., no documentation was available to show the generator set in service was exercised under load monthly for a minimum of 30 minutes between 09/01/21 to 03/31/22. Also, the generator weekly inspection was missing checks between 09/01/21 to 03/31/22. Based on an interview at the time of record review, the Maintenance Director stated the load test and weekly tests were not conducted due to no Maintenance Director during that time. The findings were reviewed with the Maintenance Director at the exit conference. 3.1-19(b)		All residents, staff and visitors could have the potential to be affected by the alleged deficiency of missing monthly generator load testing and weekly inspections for the months of September 2021-March2022. 3. The measures the facility will take or systems the facility will alter to ensure the problems will be corrected or will not recur: Maintenance Director/designee has added the testing and inspection to the TELS program as a reminder 4. Quality Assurance (QA) plans to monitor facility performance to make sure that corrections are achieved and are permanent: A QA tool was created to monitor and assure that the the generator monthly load testing and weekly inspections are done. It will be reviewed monthly for six (6)months or until an average of ninety percent (90%) compliance or greater is achieved for three (3) months. QA committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	