STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		UILDING		COMPL	
		155799	B. W	ING		08/16/	2022
	ROVIDER OR SUPPLIER		<u> </u>	614 WE	ADDRESS, CITY, STATE, ZIP COD EST 14TH STREET N, IN 46953		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID			(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		DATE
E 0000							
Bldg	conducted by the In accordance with 42 Survey Date: 08/16/ Facility Number: 01	/22	E 0	000	This Plan of Correction is the center's allegation of compliar	nce.	
	Provider Number: 1	55799					
	AIM Number: 200	136580					
	Care Marion LLC w with Emergency Pro Medicare and Medicand Suppliers, 42 C capacity of 70 and b of this survey.	42 CFR, Subpart 483.73 is NOT			Preparation and/or execution this Plan of Correction does not constitute admission or agree by the provider of the truth of facts alleged or conclusions of 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.	ot ment the	
E 0004 SS=F Bldg	484.102(a), 485.6: 485.727(a), 485.9: 491.12(a), 494.62: Develop EP Plan, Annually §403.748(a), §416: §441.184(a), §460: §483.73(a), §483.4: §485.68(a), §485.6	5(a), 483.475(a), 483.73(a), 25(a), 485.68(a), 20(a), 486.360(a),					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

TITLE

Any defiency statement 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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	NT OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER 155799	A. BUIL	A. BUILDING B. WING		COMPLETED 08/16/2022	
	PROVIDER OR SUPPLIEF			314 WE	DDRESS, CITY, STATE, ZIP COD ST 14TH STREET N, IN 46953		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	PF	ID EFIX FAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	Federal, State and preparedness required must develop estate comprehensive errorgram that mees section. The emerorgram must incitive following elements of the following eleme	an. The [facility] must tain an emergency in that must be [reviewed], ast every 2 years. The plan following: §482.15 and CAHs at ergency Plan. The [hospital apply with all applicable d local emergency uirements. The [hospital or op and maintain a mergency preparedness ts the requirements of this in all-hazards approach. Les at §483.73(a):] The LTC facility must tain an emergency in that must be reviewed, ast annually. Ities at §494.62(a):] The ESRD facility must tain an emergency in that must be [evaluated], and the properties of the plant	E 000	4	Corrective actions which wi	II he	08/22/2022
	Dasca off feedfullet	10 w and interview, the facility	LE 000	→	i. Confective actions willer W	II DE	00/22/2022

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155799	(X2) MULTIPLE C A. BUILDING B. WING	construction =-	(X3) DATE SURVEY COMPLETED 08/16/2022
	PROVIDER OR SUPPLIEI		614 W	ADDRESS, CITY, STATE, ZIP COD EST 14TH STREET DN, IN 46953	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	TION (X5) D BE OPRIATE COMPLETION DATE
	Preparedness Plan	d update the Emergency (EPP) at least annually in CFR 483.73(a). This deficient et all occupants.		accomplished for those employees and residents be affected by the deficier practice:	
	Director on 08/16/2 review date of 06/1 could be found to s and updated within interview during re Director stated the EEP has been revie year could not be for	viewed with the Maintenance		All residents have the pote be affected by this alleged deficiency practice of the Emergency Preparedness (EPP) of not being update 2. How will the facility ide other residents having the potential to be affected by same deficient practice: All residents, staff and vis could have the potential to affected by the alleged de EPP book was reviewed a updated. 3. The measures the facility alter to ensure the probler be corrected or will not recommended a updated to ensure the probler be corrected or will not recommended a task to the TELS for 2023 review and updated 4. Quality Assurance (QA to monitor facility performs make sure that corrections achieved and are permanulated and are permanulated.	d s Plan ed. Intify e the store the

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	NT OF DEFICIENCIES OF CORRECTION			ULTIPLE CO JILDING NG	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 08/16/2022	
	PROVIDER OR SUPPLIE		<u> </u>	614 WE	ADDRESS, CITY, STATE, ZIP COD EST 14TH STREET N, IN 46953	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE SICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
					the May section of the QA boowill be reviewed in May of everyear or until an average of nir percent (90%) compliance or greater is achieved for three (years. QA committee will ideany trends or patterns and ma recommendations to revise the plan of correction as indicated	ery nety 3) ntify ake ie	
E 0013 SS=F Bldg	484.102(b), 485.6 485.727(b), 485.9 491.12(b), 494.62 Development of E §403.748(b), §41 §441.184(b), §46 §483.73(b), §483 §485.68(b), §485	5(b), 483.475(b), 483.73(b), 625(b), 485.68(b), 920(b), 486.360(b),					
	develop and imple preparedness pole on the emergency (a) of this section paragraph (a)(1) of communication ple section. The policy	rocedures. [Facilities] must ement emergency icies and procedures, based y plan set forth in paragraph , risk assessment at of this section, and the lan at paragraph (c) of this cies and procedures must updated at least every 2					
	and procedures. develop and imple preparedness pol on the emergency	s at §483.73(b):] Policies The LTC facility must ement emergency icies and procedures, based y plan set forth in paragraph , risk assessment at					

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155799	ì	UILDING	NSTRUCTION	COM	ie survey ipleted 16/2022	
	PROVIDER OR SUPPLIEI N CARE MARION L		STREET ADDRESS, CITY, STATE, ZIP COD 614 WEST 14TH STREET MARION, IN 46953					
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP	JLD BE	(X5) COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	communication pl	of this section, and the lan at paragraph (c) of this cies and procedures must updated at least annually.						
	*Additional Requi ESRD Facilities:	rements for PACE and						
	procedures. The develop and imple	60.84(b):] Policies and PACE organization must ement emergency						
	on the emergency (a) of this section	icies and procedures, based y plan set forth in paragraph , risk assessment at of this section, and the						
	communication pl	an at paragraph (c) of this cies and procedures must						
	nonmedical emer limited to: Fire; ed	ment of medical and gencies, including, but not quipment, power, or water						
	disasters likely to	ed emergencies; and natural threaten the health or cipants, staff, or the public.						
		procedures must be lated at least every 2 years.						
	1 -	ities at §494.62(b):] Policies The dialysis facility must						
	1 '	ement emergency						
		icies and procedures, based						
	on the emergency	y plan set forth in paragraph						
	* *	, risk assessment at						
		of this section, and the						
	The state of the s	an at paragraph (c) of this						
		cies and procedures must						
		updated at least every 2						
	1 -	ergencies include, but are						
		, equipment or power						
		ted emergencies, water						
	supply interruption	n, and natural disasters	1				1	

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155799	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		ONSTRUCTION	(X3) DATE COMPL 08/16 /	LETED
	PROVIDER OR SUPPLIER			614 WE	ADDRESS, CITY, STATE, ZIP COD EST 14TH STREET N, IN 46953		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	area. Based on record review and Preparedness Plan's at least annually in 483.73(a). This defoccupants. Findings include: Based on records redirector on 08/16/2 review date of 06/1 could be found to so Procedures were relast year. Based on review, the Mainter documentation to so Procedures have be the last year could in the sound of the sou	viewed with the Maintenance	E 0	013	1. Corrective actions which waccomplished for those employees and residents four be affected by the deficient practice: All residents have the potentiable affected by this alleged deficiency practice of the Emergency Preparedness Plate (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 deficient EPP book was reviewed and updated. 3. The measures the facility will alter to ensure the problems who be corrected or will not recur: Maintenance Director/Designer has updated the EPP and has added a task to the TELS system for 2023 review and update. 4. Quality Assurance (QA) plated to monitor facility performance make sure that corrections are achieved and are permanent:	nd to al to n ncy. vill l vill ee tem ans	08/22/2022

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		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		JLTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAIN	OF CORRECTION	155799	B. WI			08/16/	
NAME OF P	ROVIDER OR SUPPLIER		<u> </u>	STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
	N CARE MARION L		614 WEST 14TH STREET MARION, IN 46953				
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	*	LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	DATE
E 0015 SS=C Bldg	(1), 482.15(b)(1), 4485.625(b)(1) Subsistence Need §403.748(b)(1), §4§441.184(b)(1), §4§483.73(b)(1), §48 [(b) Policies and p must develop and preparedness policon the emergency (a) of this section, paragraph (a)(1) o communication plasection. The policibe reviewed and u [annually for LTC 1 the policies and properties and properties and properties and properties and patients of shelter in place, in to the following:	3.113(b)(6)(iii), 441.184(b) 483.475(b)(1), 483.73(b)(1), 483.475(b)(1), 483.73(b)(1), 460.84(b)(1), §482.15(b)(1), 460.84(b)(1), §485.625(b)(1) 483.475(b)(1), §485.625(b)(1) 483.475(b)(1), §485.625(b)(1) 483.475(b)(1), §485.625(b)(1) 483.475(b)(1), §485.625(b)(1) 483.475(b)(1), §482.15(b)(1), 483.475(b)(1), 483.475(b)(A QA tool was created to mon the yearly updates and review the EPP. This tool is placed in the May section of the QA boo will be reviewed in May of eve year or until an average of nine percent (90%) compliance or greater is achieved for three (3 years. QA committee will iden any trends or patterns and ma recommendations to revise the plan of correction as indicated	of n nk. it ry ety 3) stiffy ke	

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CENTERS FOR MEDICARE & MEDICAID SERVICES					OMB N	O. 0938-039
STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	<u></u>	COMPLETE	ED
		155799	B. WING		08/16/20	22
			STREE	T ADDRESS, CITY, STATE, ZIP COD		
NAME OF	PROVIDER OR SUPPLIE	R		WEST 14TH STREET		
APFRIO	N CARE MARION L	IC		ION, IN 46953		
				1011, 11110000		
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	1	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROI DEFICIENCY)		OMPLETION
TAG	1	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE
	` '	ces of energy to maintain				
	the following:					
		s to protect patient health				
		r the safe and sanitary				
	storage of provisi					
	(B) Emergency lig	-				
	1 ' '	, extinguishing, and alarm				
	systems.					
	(D) Sewage and v	waste disposal.				
	r= 1 ((1)					
		ospice at §418.113(b)(6)(iii):]				
	Policies and proc					
	1 \ /	are additional requirements				
		ited inpatient care facilities				
		s and procedures must				
	address the follow	_				
	1 ' '	of subsistence needs for				
		es and patients, whether				
	1	shelter in place, include, but				
	are not limited to					
	1 ' '	medical, and pharmaceutical				
	supplies.	roos of anarquita maintain				
	the following:	rces of energy to maintain				
	1	to protect nations health				
		to protect patient health r the safe and sanitary				
		•	1			
	storage of provision (2) Emergency light					
		, extinguishing, and alarm				
	1 ' '	, exunguishing, allu alahii				
	systems. (C) Sewage and	wasta disposal	1			
		view and interview, the facility	E 0015	Corrective actions which	a will bo	0/22/2022
			E 0015		will be 0	8/22/2022
		ergency preparedness policies		accomplished for those	l l	
	_	lude at a minimum, (1) The		employees and residents for		
	_	tence needs for staff and	1	be affected by the deficient		
		they evacuate or shelter in		practice:		
	_	are not limited to the following:	1			
	(1) Food, water, me	edical, and pharmaceutical	1	All residents have the poter	ntial to	

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supplies. (ii) Alternate sources of energy to

maintain - (A) Temperatures to protect resident

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)9

be affected by this alleged

deficiency practice of the

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	OF CORRECTION	IDENTIFICATION NUMBER 155799	A. BUILDING B. WING		COMPLETED 08/16/2022
NAME OF P	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD EST 14TH STREET	
APERIO	N CARE MARION L	LC		DN, IN 46953	
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX		CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION
TAG		d for the safe and sanitary	TAG	Emergency Preparedness Pla	5.112
		s; (B) Emergency lighting; (C)		(EPP) of not being updated.	111
		iguishing, and alarm systems;		(E11) of not being aparted.	
		l waste disposal in accordance		2. How will the facility identify	,
	with 42 CFR 483.73	8(b)(1). This deficient practice		other residents having the	
	could affect all occu	ipants.		potential to be affected by the	
				same deficient practice:	
	Findings include:			AII	
	D1 1	iid-dl-M-i		All residents, staff and visitors	
		view with the Maintenance 2 at 10:50 a.m., the subsistence		could have the potential to be affected by the alleged deficie	
		n for the emergency		EPP book was reviewed and	ency.
	preparedness progra			updated including the policy for	or a
		sewage and waste outage		sewage and waste outage po	
		lable for review. Based on			
	interview at the time	e of records review, the		3. The measures the facility v	vill
	Maintenance Direct	or stated the sewage and		take or systems the facility wi	l l
	waste outage policy	could not be found.		alter to ensure the problems v	vill
				be corrected or will not recur:	
		viewed with the Maintenance		Maintenance Director/Designe	
	Director during the	exit conference.		has updated the EPP and has	
				added a task to the TELS sys	tem
				for 2023 review and update.	
				4. Quality Assurance (QA) pl	
				to monitor facility performance	
				make sure that corrections are	e
				achieved and are permanent:	
				A QA tool was created to mor	nitor
				the yearly updates and review	
				the EPP. The review will inclu	de
				going over the sewage and w	
				outage policy. This tool is place	ced
				in the May section of the QA	
				book, it will be reviewed in Ma	·
				every year or until an average ninety percent (90%) complia	
				or greater is achieved for thre	
				or greater is define year for time	

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CENTERS FOR MEDICARE & MEDICAID SERVICES							B NO. 0938-039
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING		COMPL	
		155799	B. W	ING		08/16/	/2022
NAME OF I	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD		
ADEDIO	N CARE MARION L	1.0			EST 14TH STREET		
	N CARE MARION L			WARIO	N, IN 46953		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	,	ICY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
IAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	years. QA committee will ider	ntify/	DATE
					any trends or patterns and ma	-	
					recommendations to revise the		
					plan of correction as indicated		
E 0024		6.54(b)(5), 418.113(b)(4),					
SS=C		2.15(b)(6), 483.475(b)(6),					
Bldg	, , , ,	.102(b)(5), 485.625(b)(6),					
		.727(b)(4), 485.920(b)(5),					
	491.12(b)(4), 494	.oz(b)(ວ) es-Volunteers and Staffing					
		416.54(b)(5), §418.113(b)(4),					
	- , , , , -	460.84(b)(7), §482.15(b)(6),					
	- , , , , -	83.475(b)(6), §484.102(b)(5),					
		85.625(b)(6), §485.727(b)(4),					
		491.12(b)(4), §494.62(b)(5).					
	0 ()(-), 0	(// // 3 = = (// -/					
	[(b) Policies and p	procedures. The [facilities]					
	must develop and	l implement emergency					
	preparedness poli	icies and procedures, based					
	on the emergency	/ plan set forth in paragraph					
		risk assessment at					
	. •	of this section, and the					
		an at paragraph (c) of this					
		cies and procedures must					
		updated at least every 2					
		r LTC facilities]. At a					
		cies and procedures must					
	address the follow	virig.]					
	(6) [or (4) (5) or ((7) as noted above] The use					
		n emergency or other					
		ig strategies, including the					
		for integration of State and					
	Federally designa						
		ddress surge needs during					
	an emergency.	3					

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*[For RNHCIs at §403.748(b):] Policies and procedures. (6) The use of volunteers in an

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155799		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 08/16/2022	
	PROVIDER OR SUPPLIER		614 WI	ADDRESS, CITY, STATE, ZIP COD EST 14TH STREET DN, IN 46953	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
	strategies to addre emergency. *[For Hospice at § procedures. (4) The employees in an emergency staffing process and role of Federally designate professionals to a superferency. Based on record restailed to ensure Emergency or other including the processionals to addresse or Federally designate professionals to addresse or Federally designate or Federally designate or Federally designate or Federally designates or Federally designate	view and interview, the facility ergency Preparedness Plan use of volunteers in an emergency staffing strategies, as and role for integration of designated health care dress surge needs during an edance with 42 CFR 483.73(b) practice could affect all eview with the Maintenance at 10:51 a.m., the provided as the use of volunteers in an on interview at the time of Maintenance Director stated a fivolunteers in an emergency eviewed with the Maintenance	E 0024	1. Corrective actions which wi accomplished for those employees and residents found be affected by the deficient practice: All residents have the potential 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 deficient EPP book was reviewed and updated, a policy for staffing, in case of an emergency is in pla however volunteers are not us included in said policy. 3. The measures the facility with take or systems the facility will.	d to I to n ncy. n nce, ed or

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	OF CORRECTION	IDENTIFICATION NUMBER 155799	A. BUILDING B. WING		COMPLETED 08/16/2022
	ROVIDER OR SUPPLIER		614 WE	ADDRESS, CITY, STATE, ZIP COD EST 14TH STREET IN, IN 46953	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
				alter to ensure the problems we be corrected or will not recur: Maintenance Director/Designed has updated the EPP and has added a task to the TELS system for 2023 review and update. 4. Quality Assurance (QA) plate to monitor facility performance make sure that corrections are achieved and are permanent: A QA tool was created to mone the yearly updates and review the EPP, including the policy of staffing in case of an emergent This tool is placed in the May section of the QA book, it will be reviewed in May of every year until an average of ninety percentage (90%) compliance or greater is achieved for three (3) years. Committee will identify any tree or patterns and make recommendations to revise the plan of correction as indicated.	ee ans ans ato e itor of or acy. be e or eent s QA ands
E 0029 SS=F Bldg	484.102(c), 485.62 485.727(c), 485.92 491.12(c), 494.62(Development of C §403.748(c), §416 §441.184(c), §460 §483.73(c), §483.4 §485.68(c), §485.6	5(c), 483.475(c), 483.73(c), 25(c), 485.68(c), 20(c), 486.360(c),			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		î ´	E CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	G <u></u>	COMPLETED	
		155799	B. WING		08/16/2022	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 614 WEST 14TH STREET MARION, IN 46953			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	CROSS-REFERENCED TO THE APPROP	N (X5) BE COMPLETION DATE	
	an emergency preplan that complies local laws and must least every 2 yes facilities]. Based on record review and Preparedness Plan's least annually in act 483.73(a). This definition occupants. Findings include: Based on records reduction of 16/2 review date of 16/1 could be found to standard plan was reviewed year. Based on an in review, the Mainter documentation to standard plan has been review year could not be for	viewed with the Maintenance	E 0029	1. Corrective actions which accomplished for those employees and residents for be affected by the deficient practice: All residents have the poter be affected by this alleged deficiency practice of the Emergency Preparedness F (EPP) of not being updated 2. How will the facility ident other residents having the potential to be affected by the same deficient practice: All residents, staff and visite could have the potential to affected by the alleged defice EPP book was reviewed an updated, including the Communication plan. 3. The measures the facility alter to ensure the problems be corrected or will not recumulated a task to the TELS is for 2023 review and updated.	ound to Plan tify he ors be ciency. id y will will s will ur: gnee nas ystem	

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155799		A. BUILDING B. WING	JNSTRUCTION	COMPLETED 08/16/2022			
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 614 WEST 14TH STREET MARION, IN 46953				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
E 0031 SS=C Bldg	441.184(c)(2), 482.483.73(c)(2), 484.485.68(c)(2), 485.486.360(c)(2), 491.486.360(c)(2), \$49.486.3748(c)(2), \$48.486.373(c)(2), \$48.485.68(c)(2), \$48.485.920(c)(2), \$48.485.920(c)(2). \$49.486.62(c)(2). \$49.486.	5.54(c)(2), 418.113(c)(2), 6.15(c)(2), 483.475(c)(2), 102(c)(2), 485.625(c)(2), 727(c)(2), 485.920(c)(2), .12(c)(2), 494.62(c)(2) Is Contact Information .16.54(c)(2), §418.113(c)(2), .60.84(c)(2), §482.15(c)(2), .3.475(c)(2), §484.102(c)(2), .5.625(c)(2), §485.727(c)(2), .86.360(c)(2), §491.12(c)(2), ust develop and maintain paredness communication with Federal, State and st be reviewed and updated ars [annually for LTC amunication plan must		4. Quality Assurance (QA) plato monitor facility performance make sure that corrections are achieved and are permanent: A QA tool was created to more the yearly updates and review the EPP, including the communication plan. This too 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 achief for three (3) years. QA commovill identify any trends or pattern and make recommendations are revise the plan of correction a indicated.	e to e nitor v of l is he n %) eved nittee erns to		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155799		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 08/16/2022	
	PROVIDER OR SUPPLIER		614 WI	ADDRESS, CITY, STATE, ZIP COD EST 14TH STREET DN, IN 46953	
APERIO (X4) ID PREFIX TAG	SUMMARY (EACH DEFICIEN REGULATORY OF include all of the f (2) Contact inform (i) Federal, State, emergency prepa (ii) Other sources *[For LTC Facilities Contact information (i) Federal, State, emergency prepa (ii) The State Lice Agency (iii) The Office of to Ombudsman. (iv) Other sources *[For ICF/IIDs at § information for the	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION collowing: Pation for the following: tribal, regional, and local redness staff. of assistance. Pas at §483.73(c):] (2) on for the following: tribal, regional, and local redness staff. Insing and Certification The State Long-Term Care The following:			E (X5) COMPLETION DATE
	Agency. (iv) The State Pro Agency. Based on record rev failed to ensure the communication pla information for the tribal, regional, or I staff (ii) The State I Agency (iii) The O Care Ombudsman (in accordance with	rensing and Certification tection and Advocacy view and interview, the facility emergency preparedness in includes (2) Contact following: (i) Federal, State, ocal emergency preparedness Licensing and Certification ffice of the State Long-Term iv) Other sources of assistance 42 CFR 483.73(c) (2). This buld affect all occupants.	E 0031	Corrective actions which will accomplished for those employees and residents found be affected by the deficient practice: All residents have the potential be affected by this alleged deficiency practice of the Emergency Preparedness Plan (EPP) of not being updated. How will the facility identify.	to

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Based on record review with the Maintenance

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other residents having the

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155799	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 08/16/2022
	ROVIDER OR SUPPLIER		614 W	ADDRESS, CITY, STATE, ZIP COD EST 14TH STREET DN, IN 46953	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION 2 at 10:43 a.m., the emergency	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	5.112
TAG	Director on 08/16/2 preparedness common State, Tribal emergic contact information This included The State Certification Agency Long-Term Care Of assistance. Based record review, the March the facility does have	2 at 10:43 a.m., the emergency nunication plan for Federal, ency preparedness staff was not available for review. State Licensing and y, The Office of the State mbudsman, and other sources I on interview at the time of Maintenance Director stated we the contact info but did not f the contact information for	TAG	potential to be affected by the same deficient practice: All residents, staff and visitor could have the potential to be affected by the alleged defici EPP book was reviewed and updated. 3. The measures the facility take or systems the facility walter to ensure the problems be corrected or will not recur. Maintenance Director/Design has updated the EPP official contact information and has a task to the TELS system for 2023 review and update. 4. Quality Assurance (QA) promotion to monitor facility performance make sure that corrections a achieved and are permanent. A QA tool was created to moothe yearly updates and review the EPP including the official contact information. This too placed in the May section of	s e ency. will ill will : nee s added or lans se to re : nitor w of 's ol is
				QA book. it will be reviewed in the May of every year or until an average of ninety percent (90 compliance or greater is achifor three (3) years. QA commodificated will identify any trends or pat and make recommendations revise the plan of correction indicated.	n 0%) eved nittee terns to

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155799	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/16/2022		
	PROVIDER OR SUPPLIER			614 WE	NDDRESS, CITY, STATE, ZIP COD ST 14TH STREET N, IN 46953		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO	BE	(X5) COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
E 0036	403.748(d), 416.5	64(d), 418.113(d),					
SS=F	441.184(d), 482.1	5(d), 483.475(d), 483.73(d),					
Bldg	484.102(d), 485.6						
g.	' '	20(d), 486.360(d),					
	' '						
	491.12(d), 494.62	• •					
	EP Training and 1	•					
	§403.748(d), §416	6.54(d), §418.113(d),					
	§441.184(d), §460	0.84(d), §482.15(d),					
	§483.73(d), §483.	.475(d), §484.102(d),					
	§485.68(d), §485.	.625(d), §485.727(d),					
		6.360(d), §491.12(d),					
	§494.62(d).						
	3404.02(d).						
	1 -	§403.748, ASCs at §416.54, 113, PRTFs at §441.184,					
		, Hospitals at §482.15,					
	_	2, CORFs at §485.68,					
	_	5, "Organizations" under					
		at §485.920, OPOs at					
	§486.360, and RF	HC/FHQs at §491.12:] (d)					
	Training and testing	ng. The [facility] must					
	develop and main	tain an emergency					
		ning and testing program					
		he emergency plan set forth					
	in paragraph (a) c	.					
	. • . , ,	ragraph (a)(1) of this					
		ind procedures at paragraph					
	1 ' '	, and the communication					
		(c) of this section. The					
	training and testin	ig program must be					
	reviewed and upd	lated at least every 2 years.					
	_	s at §483.73(d):] (d) Training					
	and testing. The	LTC facility must develop					
	and maintain an e	emergency preparedness					
		ig program that is based on					
	-	an set forth in paragraph (a)					
		k assessment at paragraph					
		· · · · · · · · · · · · · · · · · · ·					
	1 ' ' ' '	on, policies and procedures					
	i at paragraph (b) c	of this section, and the					I

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILD		A. BUILDING B. WING	A. BUILDING COMPLETED		
	ROVIDER OR SUPPLIER		614 W	ADDRESS, CITY, STATE, ZIP COD EST 14TH STREET DN, IN 46953	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	communication pla section. The train must be reviewed annually. *[For ICF/IIDs at § testing. The ICF/II maintain an emergand testing progra emergency plan s	an at paragraph (c) of this ing and testing program and updated at least 483.475(d):] Training and D must develop and gency preparedness training im that is based on the et forth in paragraph (a) of ssessment at paragraph			
	(a)(1) of this section at paragraph (b) of communication plasection. The train must be reviewed 2 years. The ICF/I	on, policies and procedures f this section, and the an at paragraph (c) of this ing and testing program and updated at least every			
	Training, testing, a dialysis facility mu emergency preparand patient orients on the emergency (a) of this section, paragraph (a)(1) of procedures at parand the communic of this section. The	ties at §494.62(d):] and orientation. The st develop and maintain an redness training, testing ation program that is based r plan set forth in paragraph risk assessment at of this section, policies and agraph (b) of this section, cation plan at paragraph (c) the training, testing and m must be evaluated and red years.			
	failed to review and Preparedness Plan's Plan at least annual	view and interview, the facility lupdate the Emergency (EPP) Training and Testing ly in accordance with 42 CFR scient practice could affect all	E 0036	Corrective actions which waccomplished for those employees and residents foun be affected by the deficient practice: All residents have the potential.	d to

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155799		A. BUILDING B. WING		COMPLETED 08/16/2022			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 614 WEST 14TH STREET MARION, IN 46953				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
	Director on 08/16/2 review date of 06/10 could be found to sh Testing Plan was re last year. Based on a review, the Mainten documentation to sh Testing Plan has been the last year could not be shown to be shown that the last year could not be shown to show the last year could not be shown to show the last year could not be shown to show the last year could not be shown to show the last year could not be shown to show the last year could not be shown to show the last year could not be shown to show the last year could not be shown to show the last year could not be shown to show the last year could not be shown to show the last year could not be shown to show the last year show the last year could not be shown to show the last year.	viewed with the Maintenance		be affected by this alleged deficiency practice of the Emergency Preparedness Plat (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 deficient EPP book was reviewed and updated. 3. The measures the facility with alter to ensure the problems with the problems with the problems with the enditory of the end of the enditory	ency. will li vill ee and task ans e to e hitor of g he		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		i ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		NSTRUCTION	(X3) DATE SURVEY COMPLETED	
		155799	B. WI	NG		08/16/	2022
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 614 WEST 14TH STREET MARION, IN 46953				
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE	ID PROVIDER'S PLAN OF CORR		PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
E 0041 SS=C Bldg	482.15(e), 483.73(Hospital CAH and §482.15(e) Condit (e) Emergency and The hospital must standby power systemergency plan so this section and in procedures plan so (i) and (ii) of this so §483.73(e), §485.4 (e) Emergency and The [LTC facility as implement emerge systems based on forth in paragraph §482.15(e)(1), §48 Emergency generator must be the location required Care Facilities Coulnterim Amendment 12-4, TIA 12-5, and Code (NFPA 101) Amendments TIA	(e), 485.625(e) LTC Emergency Power ion for Participation: d standby power systems. implement emergency and stems based on the et forth in paragraph (a) of the policies and et forth in paragraphs (b)(1) ection. 625(e) d standby power systems. Individual the CAH] must ency and standby power the emergency plan set (a) of this section. 83.73(e)(1), §485.625(e)(1) et or location. The elocated in accordance with ements found in the Health de (NFPA 99 and Tentative ents TIA 12-2, TIA 12-3, TIA d TIA 12-6), Life Safety and Tentative Interim 12-1, TIA 12-2, TIA 12-3, d NFPA 110, when a new of when an existing		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE	ved ittee erns	COMPLETION DATE
		3.73(e)(2), §485.625(e)(2) ator inspection and testing.					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155799		A. BUILDING C		COMPL 08/16/	ETED		
	PROVIDER OR SUPPLIER			614 WE	DDRESS, CITY, STATE, ZIP COD ST 14TH STREET N, IN 46953		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	implement the eminspection, testing requirements four Facilities Code, N Code. 482.15(e)(3), §483 Emergency generand LTC facilities] source to power ehave a plan for hopower systems opemergency, unless *[For hospitals at §483.73(g), and CThe standards incities section are apreference by the EFederal Register if 552(a) and 1 CFR the material from You may inspect a Information Resource to power systems opemergency, unless *[For hospitals at §483.73(g), and CThe standards incities section are apreference by the EFederal Register if 552(a) and 1 CFR the material from You may inspect a Information Resource (NARA). For information Resource (NARA). For information and Rec (NARA). For information and Rec (NARA) incorporated by redocument in the Fannounce the characteristics.	§482.15(h), LTC at CAHs §485.625(g):] corporated by reference in oproved for incorporation by Director of the Office of the in accordance with 5 U.S.C. It part 51. You may obtain the sources listed below. It is a copy at the CMS corporation are copy at the National ords Administration mation on the availability of ARA, call 202-741-6030, or corporations. The company of the Code are efference, CMS will publish a federal Register to inges. Protection Association, 1 k,					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING COMPLETED					
		155799	B. W	NG		08/16	08/16/2022	
NAME OF F	PROVIDER OR SUPPLIER	•		STREET A	ADDRESS, CITY, STATE, ZIP COD	-		
NAME OF F	ROVIDER OR SUPPLIER			614 WE	ST 14TH STREET			
APERIO	N CARE MARION L	LC		MARIO	N, IN 46953			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	'	th Care Facilities Code,						
		ed August 11, 2011.						
	· '	im amendment (TIA) 12-2 to						
	NFPA 99, issued	•						
	' '	FPA 99, issued August 9,						
	2012.							
	' '	FPA 99, issued March 7,						
	2013.							
	, ,	FPA 99, issued August 1,						
	2013.							
	1 ' '	FPA 99, issued March 3,						
	2014.							
	. ,	fe Safety Code, 2012						
	edition, issued Au							
	1 ' '	IFPA 101, issued August						
	11, 2011.	-DA 404 : 10 1 1						
	· '	FPA 101, issued October						
	30, 2012.	TDA 404 in a second Ontak an						
	' '	FPA 101, issued October						
	22, 2013.	TDA 101 issued October						
		FPA 101, issued October						
	22, 2013.	tandard for Emorganov and						
	. ,	standard for Emergency and ystems, 2010 edition,						
		chapter 7, issued August 6,						
	2009	onapior 1, issued August 0,						
		eview and interview, the facility	E 00	041	Corrective actions which w	ill be	08/22/2022	
		the emergency power system		<i>,</i> 11	accomplished for those	50	00/22/2022	
	_	in the Health Care Facilities			employees and residents foun	nd to		
	_	and Life Safety Code in			be affected by the deficient	0		
		CFR 483.73(e)(2). This			practice:			
		ould affect all occupants.						
		1			All residents have the potentia	al to		
	Findings include:				be affected by this alleged			
					deficiency practice of the lack	of		
	Based on records re	eview with the Maintenance			the generator monthly load tes			
		22 at 11:02 a.m., the generator			and weekly inspections from			
		load testing and weekly			09/01/2021-03/31/2022.			
		0/1/21 to 03/31/22 required by						
	-	Rased on interview at the			2 How will the facility identify			

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155799	A. BUILDING		(X3) DATE SURVEY COMPLETED 08/16/2022		
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
APERION	N CARE MARION L	LC			EST 14TH STREET N, IN 46953		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE.	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		ew, the Maintenance Director			other residents having the		
		was missing required testing			potential to be affected by the		
		Maintenance person during			same deficient practice:		
	the forementioned t	ime frame.			All		
	The findings were	reviewed with the Maintenance			All residents, staff and visitors		
	Director at the exit				could have the potential to be affected by the alleged deficie		
	Director at the exit	comerciae.			of missing generator testing a	-	
					inspections.	iiu	
					3. The measures the facility v	vill	
					take or systems the facility wil		
					alter to ensure the problems v		
					be corrected or will not recur:		
					Maintenance Director/Designe		
					has been doing the testing an		
					inspections of the generator a		
					has added a task to the TELS		
					system for both.		
					4. Quality Assurance (QA) pla		
					to monitor facility performance		
					make sure that corrections are	Э	
					achieved and are permanent:		
					A QA tool was created to mor	itor	
					the monthly load testing and		
					weekly inspections. It will be		
					reviewed monthly for six (6)		
					months or until an average of ninety percent (90%) compliant		
					or greater is achieved for thre		
					months. QA committee will	C (0)	
					identify any trends or patterns	and	
					make recommendations to rev		
					the plan of correction as		
					indicated.		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155799		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 08/16/2022	
	PROVIDER OR SUPPLIER N CARE MARION LLC	STREET ADDRESS, CITY, STATE, ZIP COD 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 APPROPRI DEFICIENCY)	(X5) COMPLETION DATE	
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).	K 0000	This Plan of Correction is the center's allegation of complia		
	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		Preparation and/or execution this Plan of Correction does not constitute admission or agree by the provider of the truth of facts alleged or conclusions of 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.	not ement the set	
K 0293 SS=E Bldg. 01	NFPA 101 Exit Signage Exit Signage				

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AND PLAN OF CORRECTION AND PLAN OF CORRECTION 155799		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 08/16/2022	
	F PROVIDER OR SUPPLIES ON CARE MARION L		STREET ADDRESS, CITY, STATE, ZIP COD 614 WEST 14TH STREET MARION, IN 46953				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
	accordance with a illumination also so lighting system. 19.2.10.1 (Indicate N/A in o occupancies with where the line of Based on observatifailed to ensure 1 of outside of the facility exit. LSC apassage, or stairway way of exit access so that it is likely to be identified by a so EXIT. The NO EX in letters 2 inches has 3/8ths inch, and the NO, unless such signing. This deficient residents in therapy. Findings include: Based on observation birector on 08/16/2 side door to the out the door was not posservations, the Management of the NO includes the side of the out the door was not posservations, the Management of the NO includes the NO interview observations, the Management of the NO includes the NO interview observations, the Management of NO EXITED THE NO EXIT	less than 30 occupants exit travel is obvious.) on and interview, the facility f 2 therapy doors to the ty were not mistaken as a 7.10.8.3.1 states any door, y that is neither an exit nor a and that is located or arranged be mistaken for an exit shall ign that reads as follows: NO IT sign shall have the word NO high, with a stroke width of a word EXIT below the word gn is an approved existing the practice could affect 8 from with the Maintenance 22 at 12:20 p.m., in therapy, the side was not an exit door and losted with a "NO EXIT" sign. The time of the faintenance Director stated the sanot an exit and the door did IT" sign posted.	K 0	293	1. Corrective actions which was accomplished for those employees and residents four be affected by the deficient practice: All residents have the potential be affected by this alleged deficiency practice of the lack "NO EXIT" sign for door eight 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 deficient of the lack of a "NO EXIT" sign door eight (8). 3. The measures the facility with alter to ensure the problems where	al to al to of a (8). y ency n for will ll will	08/22/2022

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER				COMPL	ETED
		155799	B. WING			08/16/2022	
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER				ST 14TH STREET		
APERION	N CARE MARION L	LC			N, IN 46953		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID PROVIDER'S PLAN OF CORRECTION			(X5)	
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	+	TAG	DEFICIENCY)		DATE
K 0341 SS=C Bldg. 01	and components a accordance with N Code, and NFPA Code to provide el part of the building occupied, detectio	n - Installation m is installed with systems approved for the purpose in IFPA 70, National Electric 72, National Fire Alarm ffective warning of fire in any g. In areas not continuously n is installed at each fire			4. Quality Assurance (QA) plato monitor facility performance make sure that corrections are achieved and are permanent: A QA tool was created to moniand ensure that all doors in factorial have proper signage on them. will be reviewed monthly for six (6) months or until an average ninety percent (90%) compliant or greater is achieved for three months. QA committee will identify any trends or patterns make recommendations to revithe plan of correction as indicated.	itor cility It x of ce e (3)	
		In new occupancy, stalled at notification					
	appliance circuit p	ower extenders, and					
		transmitting equipment.					
	Fire alarm system	wiring or other s are monitored for					
	integrity.	s are monitored for	1				
	18.3.4.1, 19.3.4.1,	9.6, 9.6.1.8					
	Based on observation failed to ensure 1 of continuously in property.	on and interview, the facility I fire alarm systems was per operating condition. Fire Alarm and Signaling Code,	K 03	341	Corrective actions which wi accomplished for those employees and residents foun- be affected by the deficient		08/22/2022

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155799		A. BUILDING 01 B. WING		COMPLETED 08/16/2022					
NAME OF P	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 614 WEST 14TH STREET						
APERION	N CARE MARION L	LC		DN, IN 46953					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE				
IAG	2010 Edition, Section defects and malfunct deficient practice of and visitors. Findings include: Based on observation panel with the Main at 11:15 a.m., the time alarm control panel a.m. when checked interview at the time Maintenance Direct panel had the wrong changed.	on 14.2.1.2.2 states system etions shall be corrected. This hould affect all residents, staff on of the fire alarm control etenance Director on 08/16/22 me on the display of the fire indicated the time to be 10:20 at 11:15 a.m. Based on the of observation, the or agreed the fire alarm control of time and will need to be tiewed with the Maintenance	TAG	practice: All residents have the potential 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 deficie of the fire alarm control panel not being correct. 3. The measures the facility will alter to ensure the problems where the problems with the incorrected or will not recur: Maintenance Director/Designation has had the the issue with the incorrect fire control panel time corrected. 4. Quality Assurance (QA) plate to monitor facility performance make sure that corrections are achieved and are permanent: A QA tool was created to more and ensure that the time on the fire control panel is correct. It be reviewed monthly for six (6) months or until an average ninety percent (90%) compliant or greater is achieved for three protects.	al to ency time vill l vill ee e ans e to e mitor ne will of nce				

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CENTERS FOI	R MEDICARE & MEDIC	AID SERVICES				OM	IB NO. 0938-039	
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL		
		155799	B. W	ING		08/16/	/2022	
NAME OF I	PROVIDER OR SUPPLIER	· }	•	STREET A	ADDRESS, CITY, STATE, ZIP COD			•
					EST 14TH STREET			
APERIO	N CARE MARION L	LC		MARIO	N, IN 46953			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	.TE	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	-
					months. QA committee will			
					identify any trends or patterns			
					make recommendations to reventee the plan of correction as	rise		
					indicated.			
					indicated.			
K 0521	NFPA 101							
SS=F	HVAC							
Bldg. 01	HVAC							
	Heating, ventilation	n, and air conditioning shall						
	comply with 9.2 a	nd shall be installed in						
	accordance with t	he manufacturer's						
	specifications.							
	18.5.2.1, 19.5.2.1							
		view, observation, and	K 0	521	Corrective actions which w	ill be	08/22/2022	
		ty failed to ensure 1 of 1 fire			accomplished for those			
		ere inspected and provided			employees and residents foun	d to		
	_	nce after the first year after			be affected by the deficient			
		east every four years in			practice:			
		FPA 90A. LSC 9.2.1 requires and air conditioning (HVAC)			All manislands lands that made nationalis	. 1 4 -		
		ed equipment shall be in			All residents have the potential be affected by this alleged	וו נט		
		FPA 90A, Standard for the			deficiency practice of the lack	of		
		Conditioning and Ventilating			the fire damper system inspec			
		OA, 2012 Edition, Section 5.4.8.1			and testing.	LIOIT		
	I -	shall be maintained in			and testing.			
	_	FPA 80, Standard for Fire			2. How will the facility identify			
		pening Protectives. NFPA 80,			other residents having the			
		on 19.4.1 states each damper			potential to be affected by the			
		inspected 1 year after			same deficient practice:			
		n 19.4.1.1 states the test and			· ·			
	inspection frequenc	y shall be every 4 years except			All residents, staff and visitors			
	for hospitals where	the frequency is every 6 years.			could have the potential to be			
	If the damper is equ	aipped with a fusible link, the			affected by the alleged deficie	ncy		
		ed for testing to ensure full			of the lack of the fire damper	ļ		
		-place if so equipped. The			system being inspected and	ļ		
	damper shall not be	blocked from closure in any			tested every 4 years.			

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way. All inspections and testing shall be documented, indicating the location of the fire

damper, date of inspection, name of inspector and

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3. The measures the facility will

take or systems the facility will

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155799		A. B	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/16/2022		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 614 WEST 14TH STREET MARION, IN 46953				
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR		TE.	(X5) COMPLETION	
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		ered. The documentation shall			alter to ensure the problems v	vill	
		cate when and how the			be corrected or will not recur:		
	deficiencies were corrected. This deficient practice could affect all residents.				N		
	practice could affec	t all residents.			Maintenance Director/Designo		
	Findings include:				has scheduled an inspection a		
	Findings include.				testing of the fire damper syst and for every 4 years hereafte		
	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				and for every 4 years flerealte	71.	
					4. Quality Assurance (QA) pla	ans	
					to monitor facility performance		
					make sure that corrections are		
					achieved and are permanent:		
	Maintenance Direct	or 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				A QA tool was created to mor	itor	
					and ensure that the time on th	ie	
	review and observat	tions, the Maintenance			fire damper system is inspect	ed	
		damper inspection could not			and tested every 4 years. Q	A	
		t know the last time the			committee will identify any tre	nds	
	dampers were inspe	ected.			or patterns and make		
					recommendations to revise th		
	The findings were r Director at the exit	eviewed with the Maintenance conference.			plan of correction as indicated	l.	
	3.1-19(b)						
K 0531	NFPA 101						
SS=E	Elevators						
Bldg. 01	Elevators						
	2012 EXISTING						
		with the provision of 9.4.					
		ected and tested as					
	1 -	A17.1, Safety Code for					
		calators. Firefighter's					
	service is operate record.	d monthly with a written					
		conform to ASME/ANSI					
	_	le for Existing Elevators					
	1	ll existing elevators, having					
		of 25 feet or more above or					
		at best serves the needs of					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155799		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 08/16/2022		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 614 WEST 14TH STREET MARION, IN 46953					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE	
	Requirements of A (Includes firefighter recall and smoke of firefighter's service key operation, madetectors, and eledetectors.) 19.5.3, 9.4.2, 9.4.3 Based on record revialled to maintain to firefighter recall in Testing. LSC 9.4.6 fire fighters' emerged with 9.4.3 shall be swith a written record kept on the premise A17.1/CSA B44, Same Escalators. This defistaff that use the electric findings include: Based on record revial based on record revial for the elevant staff elevator was march 2022. Based record review, the Maintenance Directric findings monthly Maintenance Directric findings monthly Maintenance Directric findings monthly findings	a with Firefighter's Service ASME/ANSI A17.3. Asher's service Phase I key detector automatic recall, a Phase II emergency in-car chine room smoke vator lobby smoke Briew and interview, the facility esting of 1 of 1 staff elevator accordance with 9.4.6, Elevator accordance with 9.4.6, Elevator accordance with 9.4.6 with ency operations in accordance subject to a monthly operation d of the findings made and as as required by ASME aftery Code for Elevators and deient practice would affect evator. The with the Maintenance 2 at 10:53 a.m., the monthly tor firefighter recall for the missing from September 2021 to on interview at the time of Maintenance Director stated by tests were missing due to no or during that time.	K 0	531	1. Corrective actions which we accomplished for those employees and residents foun be affected by the deficient practice: All residents have the potential 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 deficien of missing monthly testing for elevator firefighter recall for the staff elevator from September 2021- March 2022. 3. The measures the facility will alter to ensure the problems we be corrected or will not recur: Maintenance Director/Designer.	ncy e	08/22/2022	

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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 08/16/2022	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 614 WEST 14TH STREET MARION, IN 46953				
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	(X5) COMPLETION
K 0741 SS=E Bldg. 01	NFPA 101 Smoking Regulati Smoking Regulati	ons		TAG	has been completing the monitesting on the elevator firefight recall since April 2022. 4. Quality Assurance (QA) plate to monitor facility performance make sure that corrections are achieved and are permanent: A QA tool was created to moniand assure that the monthly testing for the elevator firefight recall is done. It will be review monthly for six (6)months or uran average of ninety percent (compliance or greater is achief for three (3) months. QA committee will identify any tree or patterns and make recommendations to revise the plan of correction as indicated.	ans e to e nitor ter wed intil (90%) eved nds	DATE
	shall include not le provisions: (1) Smoking shall ward, or compartr liquids, combustibused or stored an location, and such signs that read No posted with the in smoking. (2) In health care smoking is prohib prominently place	be prohibited in any room, ment where flammable be gases, or oxygen is d in any other hazardous area shall be posted with D SMOKING or shall be ternational symbol for no occupancies where ited and signs are d at all major entrances, with language that prohibits					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M				SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	A. BUILDING <u>01</u>			COMPLETED	
		155799	B. WING 08/16/2022			/2022		
				CTREET	ADDRESS, CITY, STATE, ZIP COD			
NAME OF P	PROVIDER OR SUPPLIEF	₹						
ADEDION	N CARE MARION I	1.0			EST 14TH STREET			
APERIO	N CARE MARION L	LC		WARIO	N, IN 46953			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	smoking shall not	be required.						
	(3) Smoking by pa	atients classified as not						
	responsible shall	be prohibited.						
	(4) The requireme	ent of 18.7.4(3) shall not						
	apply where the p	atient is under direct						
	supervision.							
	(5) Ashtrays of no	ncombustible material and						
	_	be provided in all areas						
	where smoking is	· ·						
	1 ' '	ers 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							
		on and interview; the facility	KO	741	Corrective actions which w	ill be	08/22/2022	
		mbustible gases were not			accomplished for those			
		oking areas. This deficient			employees and residents four	nd to		
	1 ~	et 10 residents using the			be affected by the deficient			
	resident smoking ar	rea			practice:			
	Findings include:				All residents have the potential	al to		
	I mamga maraaca				be affected by this alleged	11 10		
	Based on observation	on with the Maintenance			deficiency practice of the prop	ane		
		22 at 12:10 p.m., the resident			tank sitting inside the designa			
		propane tank sitting inside the			smoking area.			
		g area. Based on interview at						
		tion, the Maintenance Director			2. How will the facility identify	,		
		sed for the grill and moved the			other residents having the			
	tank from the smok				potential to be affected by the			
					same deficient practice:			
	The findings were r	reviewed with the Maintenance						
	Director at the exit	conference.			All residents, staff and visitors	;		
					could have the potential to be			
	3.1-19(b)				affected by the alleged deficie	ency		
					of a propane tank sitting inside	e the		
					designated smoking area.			
					3. The measures the facility v			
					take or systems the facility wil			
					alter to ensure the problems v	vill		

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

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CENTERS FOR MEDICARE & MEDICAID SERVICES						OM	IB NO. 0938-039	
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>01</u>			COMPLETED	
		155799	B. W	ING		08/16	/2022	
NAME OF PROVIDER OR SUPPLIER APERION CARE MARION LLC (X4) ID SUMMARY STATEMENT OF DEFICIENCIE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			614 WE	ADDRESS, CITY, STATE, ZIP COD EST 14TH STREET N, IN 46953 PROVIDER'S PLAN OF CORRECTION	P COD			
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ГЕ	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
K 0918	NFPA 101				be corrected or will not recur: Maintenance Director moved to propane tank as soon as it was brought to his attention. 4. Quality Assurance (QA) plat to monitor facility performance make sure that corrections are achieved and are permanent: A QA tool was created to monitand assure that the the propartank is stored in a none smokinarea. It will be reviewed montfor 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 trenor patterns and make recommendations to revise the plan of correction as indicated.	ins to itor ne ng thly ved		
SS=F Bldg. 01	Electrical Systems Electrical Systems System Maintenar The generator or source and associ of supplying servic 10-second criterio monthly test, a pro annually confirm to safety and critical and testing of the	s - Essential Electric Syste s - Essential Electric nce and Testing other alternate power iated equipment is capable ce within 10 seconds. If the in is not met during the ocess shall be provided to his capability for the life branches. Maintenance generator and transfer ormed in accordance with						

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Generator sets are inspected weekly, exercised under load 30 minutes 12 times a

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155799		(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 08/16/2022	
	PROVIDER OR SUPPLIEI N CARE MARION L		614 W	ADDRESS, CITY, STATE, ZIP COD EST 14TH STREET DN, IN 46953	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	once every 36 mo Scheduled test ur a complete simula automatic or man loads, and are copersonnel. Mainteenergy power sou accordance with Noircuit breakers air program for periodomponents is estimated and readily availated and circuits are mand separate from Minimizing the poemergency power consideration for 6.4.4, 6.5.4, 6.6.4 NFPA 111, 700.10 Based on record refailed to maintain a monthly generator and weekly inspect 6.4.4.1.1.4(a) of 20 testing of the generelectrical system to 110, the Standard frowers Systems, Corequires diesel genere exercised at least of 30 minutes. Section Power Supply Systappurtenant compoweekly and exercise	ual transfer of all EES inducted by competent inance and testing of stored irces (Type 3 EES) are in inspected annually, and a dically exercising the itablished according to uirements. Written records ind testing are maintained ble. EES electrical panels arked, readily identifiable, in normal power circuits. Insibility of damage of the is source is a design inew installations. (NFPA 99), NFPA 110,	K 0918	1. Corrective actions which waccomplished for those employees and residents four be affected by the deficient practice: All residents have the potentiabe affected by this alleged deficiency practice of the lack written record of monthly genload testing and weekly insperfrom 09/01/2021-03/31/2022 2. How will the facility identify other residents having the potential to be affected by the	al to a of erator ection

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performance, exercising period, and repairs for the

generator to be regularly maintained and available

Event ID:

66UD21

Facility ID: 012809

same deficient practice:

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PI		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>01</u>		01	COMPLETED	
		155799	B. WI	NG		08/16	/2022
NAME OF PROVIDER OR SUPPLIER APERION CARE MARION LLC			614 WE	ADDRESS, CITY, STATE, ZIP COD EST 14TH STREET N, IN 46953			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DROVIDERIC DI AMI OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TC	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	.16	DATE
	for inspection by th	e authority having			All residents, staff and visitors		
	jurisdiction. This d	leficient practice could affect all			could have the potential to be		
	occupants.				affected by the alleged deficie	ncy	
					of missing monthly generator	-	
	Findings include:				testing and weekly inspections	s for	
					the months of September		
	Based on records re	eview with the Maintenance			2021-March2022.		
	Director on 08/16/2	22 at 10:30 a.m., no	1				
	documentation was	available to show the			3. The measures the facility v	vill	
	generator set in ser	vice was exercised under load			take or systems the facility wil	l	
	monthly for a minii	mum of 30 minutes between			alter to ensure the problems w	/ill	
	09/01/21 to 03/31/2	22. Also, the generator weekly			be corrected or will not recur:		
	inspection was miss	sing checks between 09/01/21					
	to 03/31/22. Based	on an interview at the time of			Maintenance Director/designe	е	
	record review, the l	Maintenance Director stated			has added the testing and		
	the load test and we	eekly tests were not conducted			inspection to the TELS progra	m	
	due to no Maintena	nce Director during that time.			as a reminder		
		reviewed with the Maintenance			4. Quality Assurance (QA) pla	ans	
	Director at the exit	conference.			to monitor facility performance	e to	
	3.1-19(b)				make sure that corrections are	e	
					achieved and are permanent:		
					A QA tool was created to mon	itor	
					and assure that the the genera	ator	
					monthly load testing and week	dy	
			1		inspections are done. It will b	e	
			1		reviewed monthly for six (6)mo	onths	
					or until an average of ninety		
			1		percent (90%) compliance or		
					greater is achieved for three (3)	
			1		months. QA committee will		
			1		identify any trends or patterns	and	
			1		make recommendations to rev	/ise	
			1		the plan of correction as		
			1		indicated.		

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