| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | X2) MULTIPLE CONSTRUCTION | X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155799 | A. BUILDING -- <br> B. WING | 07/27/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| APERION CARE MARION LLC | 614 WEST 14TH STREET <br> 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 |
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| E 0000 <br><br> Bldg. -- | A Post Survey Revisit (PSR) to the Emergency Preparedness Survey conducted on 06/15/21 was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. <br><br> Survey Date: 07/27/21 <br><br> Facility Number: 012809 <br> Provider Number: 155799 <br> AIM Number: 200136580 <br><br> At this PSR survey, Aperion Care Marion LLC was found in 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 38 at the time of this survey. <br><br> Quality Review completed on 08/02/21 | E 0000 | *This Plan of Correction is the center's credible allegation of compliance.* <br><br> *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.* <br><br> *REQUESTS DESK REVIEW* | |
| K 0000 <br><br> Bldg. 01 | A Post Survey Revisit (PSR) to the Emergency Preparedness Survey conducted on 06/15/21 was conducted by the Indiana Department of Health in accordance 42 CFR Subpart 483.90(a). <br><br> Survey Date: 07/27/21 <br><br> Facility Number: 012809 <br> Provider Number: 155799 <br> AIM Number: 200136580 <br><br> At this PSR survey, Aperion Care Marion LLC was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR | K 0000 | *This Plan of Correction is the center's credible allegation of compliance.* <br><br> *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* | |

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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| | 155799 | A. BUILDING 01<br>B. WING | 07/27/2021 |

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| | 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.<br><br>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 38 at the time of this survey.<br><br>All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered.<br><br>Quality Review completed on 08/02/21 | | *federal and state law.*<br><br>*REQUESTS DESK REVIEW* | |
| K 0291<br>SS=F<br>Bldg. 01 | NFPA 101<br>Emergency Lighting<br>Emergency Lighting<br>Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9.<br>18.2.9.1, 19.2.9.1<br>Based on records review, observation, and interview, the facility failed to ensure 1 of 1 battery backup lights was tested monthly. Section 7.9.3.1.1 (1) requires functional testing shall be conducted monthly, with a minimum of 3 weeks and a maximum of 5 weeks between tests, for not less than 30 seconds and (5) Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect all building occupants when work is needed in the transfer switch room during a power outage. | K 0291 | K 291<br>1. Immediate actions taken for those residents identified: No residents were directly affected.<br>2. All residents, visitors and staff could be affected. However, no one was affected.<br>3. Measures put into place / system changes: Maintenance director / designee will begin using the Tels log system to emergency lights testing. Additionally, the maintenance director completed | 08/11/2021 |

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| | Findings include:<br><br>Based on an observation during a tour of the facility with the Maintenance Director on 07/27/21 at 1:34 p.m., there was a battery powered emergency light in the transfer switch room. Based on records review at 1:40 p.m., documentation of a monthly 30 second test for the battery powered emergency light was not available for review. Based on an interview at the time of record review and observation, the Maintenance Director confirmed there is a battery powered light in the transfer switch room and stated he has been conducting the 30 second test but just got access to the "TELS" electronic maintenance system and has not documented the tests. The finding was reviewed with the Maintenance Director during the exit conference.<br><br>This deficiency was cited on 06/15/21. The facility failed to implement a systemic plan of correction to prevent recurrence.<br><br>3.1-19(b) | | the emergency light test on August 5, 2021.<br>4. How the corrective actions will be monitored: Maintenance director shall log all of his activities daily in Tels. Administrator/designee shall check Tels weekly to ensure maintenance director’s tasks are completed timely. This audit will be conducted weekly and reported in the QAA meeting for 6 months and quarterly thereafter.<br>Date of Compliance: 8/11/21 | |
| K 0363<br>SS=E<br>Bldg. 01 | NFPA 101<br>Corridor - Doors<br>Corridor - Doors<br>Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by | | | |

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| | CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material.<br>Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies.<br><br>19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485<br>Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. | | | |
| | Based on observation and interview, the facility failed to ensure 5 of 64 resident room corridor doors were provided with a means suitable for keeping the door closed, had no impediment to closing, latching and would resist the passage of smoke. This deficient practice could affect 10 residents.<br><br>Findings include:<br><br>Based on observation with the Maintenance Director on 7/27/21 from 1:15 p.m. to 1:45 p.m., the | K 0363 | **K 363**<br>**1. Immediate actions taken for those residents identified: No residents were directly affected.**<br>**2. All residents, visitors and staff could be affected. However, no one was affected.**<br>**3. Measures put into place / system changes: Maintenance director / designee will begin using the Tels log system to log** | 08/11/2021 |

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| | corridor resident room doors to rooms E121, E134, D105, D120, and D131 were propped open with trashcans. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned corridor doors would not close unless the trashcans were moved first. The finding was reviewed with the Maintenance Director during the exit conference.<br><br>This deficiency was cited on 06/15/21. The facility failed to implement a systemic plan of correction to prevent recurrence.<br><br>3.1-19(b) | | **door inspections. Additionally, the maintenance director removed the trash cans and repaired the door hinges on August 5, 2021.**<br>**4. How the corrective actions will be monitored:**<br>**Maintenance director shall log all of his activities daily in Tels. Administrator/designee shall check Tels weekly to ensure maintenance director's tasks are completed timely. This audit will be conducted weekly and reported in the QAA meeting for 6 months and quarterly thereafter.**<br>Date of Compliance: 8/11/21 | |
| K 0741<br>SS=E<br>Bldg. 01 | NFPA 101<br>Smoking Regulations<br>Smoking Regulations<br>Smoking regulations shall be adopted and shall include not less than the following provisions:<br>(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.<br>(2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required.<br>(3) Smoking by patients classified as not responsible shall be prohibited. | | | |

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| | (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision.<br>(5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted.<br>(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.<br>18.7.4, 19.7.4 | | | |
| | Based on observation and interview; the facility failed to ensure 2 of 3 smoking areas were maintained by disposing cigarette butts in a metal or noncombustible container with self-closing cover devices. This deficient practice could affect staff and 25 residents using the D-hall exit.<br><br>Findings include:<br><br>Based on observation during a tour of the facility with the Maintenance Director on 07/27/21 at 1:30 p.m., in and round the staff smoking area outside of the D-hall exit and by the employee entrance there were over 30 cigarette butts disposed on the ground. Also, inside the building by the employee entrance there was a trashcan mixed with trash and cigarette butts. Based on interview at the time of observations, the Maintenance Director agree there were cigarette butts on the ground in the aforementioned locations and cigarette butts were disposed in a trashcan inside of the building. The finding was reviewed with the Maintenance Director during the exit conference.<br><br>This deficiency was cited on 06/15/21. The facility failed to implement a systemic plan of correction to prevent recurrence.<br><br>3.1-19(b) | K 0741 | K 741<br>1. Immediate actions taken for those residents identified: No residents were directly affected.<br>2. All residents, visitors and staff could be affected. However, no one was affected.<br>3. Measures put into place / system changes: Maintenance director / designee will begin using the Tels log system to log grounds inspections. Additionally, the maintenance director will check facility grounds daily Monday-Friday and remove cigarette butts. All butts were removed 8/11/21 and no smoking signs were posted.<br>4. How the corrective actions will be monitored: Maintenance director shall log all of his activities daily in Tels. Administrator/designee shall check Tels weekly to ensure maintenance director's tasks are completed timely. This audit will be conducted weekly and reported in the QAA meeting for 6 months and quarterly thereafter. | 08/11/2021 |

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