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	07/05/2023

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: 07/05/23 Facility Number: 012809 Provider Number: 155799 AIM Number: 201136580 At this Emergency Preparedness survey, Aperion Care Marion 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 47 at the time of this survey. Quality Review completed on 07/10/23	E 0000		
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: 07/05/2023 Facility Number: 012809 Provider Number: 155799 AIM Number: 201136580 At this Life Safety Code survey, Aperion Care Marion was found not in compliance with Requirements for Participation in	K 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Tamera Shirels	ED	08/01/2023

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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	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 was determined to be of Type V111 construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, areas open to the corridors and in the resident sleeping rooms. The facility has a capacity of 70 and had a census of 47 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 07/10/23			
K 0100 SS=E Bldg. 01	NFPA 101 General Requirements - Other General Requirements - Other List in the REMARKS section any LSC Section 18.1 and 19.1 General Requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Based on observation and interview, the facility failed to maintain latching hardware on 1 of 1 smoke barrier doors in the D hall. LSC 4.6.12.3 requires existing life safety features obvious to the public if not required by the Code, shall be either maintained or removed. This deficient practice could affect staff and residents in the D-hall. Findings include:	K 0100	**Tag number: K100** I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Outside vender, Koorson was called on 07/05/2023 to evaluate the door. II. How other residents having the potential to be affected	07/21/2023

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	Based on observation with the Director of Plant Operations (DPO) on 07/05/23 at 11:00 a.m., the set of smoke barrier doors to the D-hall was provided with latching hardware but failed to latch when tested. Based on interview at the time of observation, the DPO agreed the smoke doors were equipped with latching devices, but one door did not properly latch when tested. The DPO contacted a contractor to repair the door latch at the time of observation. The finding was reviewed with the Executive Director and DPO during the exit conference. 3.1-19(b)		by the same deficient practice will be identified and what corrective action(s) will be taken; All smoke barrier doors will be check by Koorson to ensure proper latching occurs when doors are tested. . III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; Maintenance Supervisor will do daily check on the D hall door until the door is fixed. IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; The Maintenance Supervisor /designee will check every fire doors 3 times a week for 4 weeks and then weekly. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	

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K 0225 SS=E Bldg. 01	NFPA 101 Stairways and Smokeproof Enclosures Stairways and Smokeproof Enclosures Stairways and Smokeproof enclosures used as exits are in accordance with 7.2. 18.2.2.3, 18.2.2.4, 19.2.2.3, 19.2.2.4, 7.2 Based on observation and interview, the facility failed to ensure items stored in 1 of 3 fire escape stairways would not interfere with egress. LSC 7.2.2.5.1 states; Open space within the exit enclosure shall not be used for any purpose that has the potential to interfere with egress. This deficient practice could affect residents or staff using the back stairwell. Findings include: Based on observation on 07/05/23 at 12:40 p.m., during a tour of the facility with the Director of Plant Operations, the back stairwell in the basement had over 30 padded chairs stored in the stairwell. Based on interview at the time of observation, the DPO acknowledged the aforementioned stairwell as being used for storage. This finding was reviewed with the Executive Director and DPO at the exit conference. 3.1-19(b)	K 0225	Tag number K 225 I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Chairs were removed for under the back stairwell immediately. II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All stairwells were checked to assure that nothing was being stored under them. III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; All staff was educated on where not to store items. IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; Maintenance supervisor/designee will do inspections under the stairwells daily, Monday-Friday.	07/21/2023

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			The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	
K 0511 SS=D Bldg. 01	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 Based on observation and interview, the facility failed to ensure 2 of 2 ground fault circuit interrupter (GFCI) were properly maintained for protection against electric shock. NFPA 70, NEC 2011 Edition at 210.8 Ground-Fault Circuit-Interrupter Protection for Personnel, states, ground-fault circuit-interruption for personnel shall be provided as required in 210.8. This deficient practice could affect 2 residents and kitchen staff. Findings include: Based on observation with the Director of Plant Operations (DPO) on 07/05/23 at 10:40 a.m. and	K 0511	Tag number K511 I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; The 2 GFCI electric receptacles that were damaged were fixed on 07/05/2023 II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All outlet electric receptacles were	07/21/2023

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	11:45 a.m., when the GFCI electric receptacle by the water fountain at the front entrance area and one in the kitchen prep area were found to be damaged. The manual trip button was missing and therefore leaving an open area on the face of the receptacle. Based on interview at the time of observation, the DPO agreed the GFCI electric receptacles mentioned were damaged and needed to be replaced. The findings were reviewed with the Executive Director and the DPO during the exit conference. 3.1-19(b)		inspected by outside contractor for the July 2023 yearly inspection and fixed/replaced as needed. III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; Yearly receptacles inspections will be done in July of every year to ensure that the receptacles are in good working order. IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; Monthly inspections of all receptacles will be done by the Maintenance Supervisor /designee. **The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.**	

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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 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 1 of 2 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 10 residents in the courtyard. Findings include:	K 0741	Tag number: K 741 I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Smoking areas were cleaned up of all cigarette butts.	07/21/2023

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	Based on observation during a tour of the facility with the Director of Plant Operations (DPO) on 07/05/23 at 10:55 a.m., in the courtyard resident smoking area there were over 20 cigarette butts disposed on the ground in and around the smoking area. Based on interview at the time of observations, the DPO agreed there were cigarette butts on the ground in the aforementioned location. This finding was reviewed with the Executive Director and DPO during the exit conference. 3.1-19(b)		II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All resident and staff were reminded that the red cans in smoking areas were the only place that cigarette butts are to be placed. III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; All staff have been educated to inspect the smoking area for butts that were dropped by residents, after each smoking session. IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e what quality assurance program will be put into place; the Maintenance supervisor/designee will inspect the smoking court yard 3 times a week to ensure staff and residents are depositing cigarette butts in the red can. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make	

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			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 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			

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	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 records review and interview, the facility failed to ensure 1 of 1 emergency task generator battery backup lights were maintained. NFPA 110, 2010 Edition at section 7.3.1 requires the Level 1 or Level 2 EPS equipment location(s) shall be provided with battery-powered emergency lighting. This requirement shall not apply to units located outdoors in enclosures that do not include walk-in access. 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, (3) Functional testing shall be conducted annually for a minimum of 1 1/2 hours if the emergency lighting system is battery powered 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 residents in the facility. Findings include: Based on records review with the Director of Plant Operations (DPO) on 07/05/23 at 01:15 p.m., no documentation was available for review to show the emergency battery powered light at the generator was tested annually for a minimum of 90 minutes. Based on an interview at the time of record review, the DPO stated there is a battery powered light at the generator and the annual test for the light was not conducted. This finding was reviewed with the Executive Director and DPO at the exit conference. 3.1-19(b)	K 0918	Tag number: K918 I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; All 30 minute and 90 minute test results were located on 07/05/2023, for 2022 and 2023. II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: Written records of visual inspections will be kept together, both 30 and 90 minute test will be kept in the Maintenance Supervisor office, in the same file. III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; The Nurses and QMAs were in-serviced on labeling, dates, and storage of medications. The Maintenance Supervisor was educated on keeping all test results in one area for easy access. IV. How the corrective action(s) will be monitored to ensure the deficient practice will	07/21/2023

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			not recur i.e., what quality assurance program will be put into place; The Maintenance Supervisor/designee will audit the 30 and 90 minute logs monthly and update as needed. . The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	
K 0920 SS=D Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension			

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	cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 Based on observation and interview, the facility failed to ensure 1 of 1 flexible cord power strip in patient care location met the required UL rating of 1363A or 60601-1. This deficient practice can affect 2 residents in the therapy gym. Findings include: Based on observations during a tour of the facility with the Director of Plant Operations (DPO) on 07/05/23 at 10:50 a.m., a power strip was in use in the therapy gym where resident care was provided that did not meet 1363A or 60601-1. Based on interview at the time of observation, the Maintenance Director agreed a power strip was in use in a resident care area and did not meet 1363A or 60601-1. This finding was reviewed with the Executive Director and DPO at the exit conference. 3.1-19(b)	K 0920	Date of compliance: Tag number: K920 I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; The un-approved cord was remove immediately from the therapy department. II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; A sweep of all areas in the building was done to ensure that no un-approved cords were in the building. III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; All staff was educated on no out side cords being used unless approved by the Maintenance Supervisor. IV. How the corrective action(s) will be monitored to	07/21/2023

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			ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; The Maintenance Supervisor /designee will do weekly sweeps of all areas in the building to ensure no un-approved cords are being used. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	
K 0923 SS=E Bldg. 01	NFPA 101 Gas Equipment - Cylinder and Container Storag Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of			

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(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
	noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99)			
	Based on observation and interview, the facility failed to ensure 11 of over 40 cylinders of nonflammable gases such as oxygen were properly secured from falling. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 11.3.2 states storage for nonflammable gases greater than 8.5 cubic meters (300 cubic feet) but less than 85 cubic meters (3000 cubic feet) shall comply with 11.3.2.1 through 11.3.2.3. NFPA 99, Section 11.3.2.6 states cylinder or container restraints shall comply with 11.6.2.3. Section 11.6.2.3(11) states freestanding cylinders shall be properly chained or supported in a proper cylinder stand or cart. This deficient practice could affect 10 residents in	K 0923	Tag number: K 923 I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; All oxygen tanks were sat up and placed in the tank holder. II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; Signs were	07/21/2023

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	07/05/2023

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	one smoke compartment. Findings include: Based on observations during a tour of the facility with the Director of Plant Operations (DPO) on 07/05/23 at 11:10 a.m., eleven 'E' type oxygen cylinders were standing upright on the floor of the oxygen storage/trans-filling room and were not properly chained or supported in a proper cylinder stand or cart. Based on interview at the time of observation, the DPO acknowledged 11 'E' type oxygen cylinders in the oxygen storage/trans-filling room were not properly chained or supported in a proper cylinder stand or cart. The finding was reviewed with the Executive Director and the DPO during the exit conference. 3.1-19(b)		placed as a reminder of putting all oxygen cylinders in the holder. III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; All staff was educated on the proper placement of oxygen tanks, empty or full. IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; The DON/designee will audit the oxygen room daily, Monday-Friday to ensure proper placement of oxygen tanks. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	