STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155799	A. BUILDING -- B. WING	08/08/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 08/08/24 Facility Number: 012809 Provider Number: 155799 AIM Number: 200136580 At this Emergency Preparedness 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 56 at the time of this survey. Quality Review completed on 08/15/24	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: 08/08/24 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	K 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Tamera Shirels	ED	08/29/2024

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 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 56 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 08/15/24			
K 0223 SS=E Bldg. 01	NFPA 101 Doors with Self-Closing Devices Doors with Self-Closing Devices Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: * Required manual fire alarm system; and * Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and * Automatic sprinkler system, if installed; and * Loss of power. 18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8 Based on observation and interview, the facility failed to ensure 1 of 1 laundry corridor doors to a	K 0223	K223	08/27/2024

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	hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2. This deficient practice could affect staff in the basement. Findings include: Based on observations with the Maintenance Director on 08/08/24 at 11:00 a.m., the laundry room contained fuel fired dryers making the room a hazardous area. The door to the room was self-closing but was held open with a door wedge from the front of the door. Based on interview at the time of observation, the Maintenance Director agreed the door was held open with a device that did not release with the fire alarm and did removed the door wedge. This finding was reviewed with the Maintenance Director and Administrator during the exit conference. 3.1-19(b)		I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Door wedges were removed. 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 self-closing doors have been identified and labeled as a reminder to staff. 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 Director/designee educated all staff on self-closing doors and that they are not to be wedged open.** 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 Director/designee will audit the self-closing doors, 5x a week x 4 weeks, 3x a week x 4 weeks, then weekly x 4 months.** The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until an average of 90% compliance or greater is achieved	

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			x4 consecutive weeks. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors 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 CMS regulation. These requirements do not			

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	apply to auxiliary spaces that do not contain flammable or combustible material. 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. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 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 3 of 10 facility services corridor doors 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 15 residents in one smoke compartment Findings include: Based on observation with the Maintenance Director on 08/08/24 at 12:15 p.m., the kitchen, electrical room, private dining, and beauty shop	K 0363	K223 I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Door wedges were removed. 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	08/27/2024

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	corridor doors were propped open with a door wedge from the front. Based on an interview at the time of observation, the Maintenance Director agreed the aforementioned corridor doors were propped open with a door wedge from the front. This finding was reviewed with the Maintenance Director and Administrator during the exit conference. 3.1-19(b)		self-closing doors have been identified and labeled as a reminder to staff. 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 Director/designee educated all staff on self-closing doors and that they are not to be wedged open.** 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 Director/designee will audit the self-closing doors, 5x a week x 4 weeks, 3x a week x 4 weeks, then weekly x 4 months.** The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until an average of 90% compliance or greater is achieved x4 consecutive weeks. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	
K 0761 SS=F Bldg. 01	NFPA 101 Maintenance, Inspection & Testing - Doors Maintenance, Inspection & Testing - Doors			

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	Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80)			
	Based on observation, records review, and interview, the facility failed to ensure annual inspection and testing of 4 of 4 fire door assemblies were completed in accordance with LSC 19.1. and with the requirements of NFPA 80, Standard for Fire Doors and Other Opening Protectives. This deficient practice could affect all residents. Findings include: Based on record review with the Maintenance Director on 08/08/24 at 10:00 a.m., the annual fire door inspections were past due. The annual fire door inspection documentation had an inspection date of 04/30/23. No other documentation was available to show the facility's fire doors were inspected within the last 12 months. Based on interview at the time of records review and observation, the Maintenance Director stated the annual fire door inspections were past due and are waiting for the contractor. This finding was reviewed with the Maintenance Director and Administrator during the exit	K 0761	**Tag number: K 761** I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Safe Care was contacted immediately and date to inspect set for 08/12/2024. 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 fire door s were inspected by outside contractor for the August 2024 yearly inspection. 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 fire door inspections will be done in May of every year to ensure that the doors are in good working order.	08/27/2024

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	conference. 3.1-19(b)		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 Director/designee will check every fire door weekly times 4 weeks and then monthly.** The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until an average of 90% compliance or greater is achieved x4 consecutive weeks. 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			

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	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 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 cords power-strips powering medical equipment met the required UL rating of 1363A or 60601-1. This deficient practice affects one resident in room D152. Findings include: Based on observations with the Maintenance Director on 08/08/24 at 11:55 a.m., an oxygen concentrator was plugged in to a power strip that did not meet 1363A or 60601-1. Based on interview at the time of observation, the Maintenance Director agreed an oxygen concentrator was plugged in to a power strip that did not meet 1363A or 60601-1 and did remove the power strip and plugged the concentrator into the wall. This finding was reviewed with the Maintenance Director and Administrator during the exit conference. 3.1-19(b)	K 0920	**Tag number: K 920** 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 removed immediately from the resident's room. 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-approve 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 Maintenance Director. IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur	08/27/2024

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			i.e., what quality assurance program will be put into place; **Maintenance Director/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 for 6 months or until an average of 90% compliance or greater is achieved x4 consecutive weeks. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	