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	09/30/2024

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
K 0000 Bldg. 01	A Post Survey Revisit (PSR) to the Life Safety Code Recertification and State Licensure Survey conducted on 08/08/24 was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 09/30/24 Facility Number: 012809 Provider Number: 155799 AIM Number: 200136580 At this PSR 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 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 10/02/24	K 0000		
K 0363 SS=E	NFPA 101 Corridor - Doors			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Tamera Shirels	ED	10/15/2024

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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Bldg. 01	Based on observation and interview, the facility failed to ensure 2 of 2 resident area 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 09/30/24 at 11:15 a.m., the private dining room and the therapy room corridor doors were propped open with a door wedge and a chair from the front. Based on an interview at the time of observation, the Maintenance Director agreed the aforementioned corridor doors were propped open from the front. This finding was reviewed with the Maintenance Director and Administrator during the exit conference. This deficiency was cited on 08/08/24. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-19(b)	K 0363	Tag number: K 0363 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 door's hydraulics were removed, none were designated as must have hydraulics. III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; Doors do not have hydraulic closers on them and they may stay 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 all doors, 5xa week x 4 weeks, 3x a week x 4 weeks and then weekly x 4 months to ensure no doors have anything in front of them while open. The results of these audits will be	10/15/2024

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			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 0741 SS=E Bldg. 01	NFPA 101 Smoking Regulations Based on observation and interview, the facility failed to ensure 1 of 1 smoking areas and 1 of 1 nonsmoking 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 20 residents using two exits. Findings include: Based on observation with the Maintenance Director on 09/30/24 at 11:08 a.m., outside the employee exit (a nonsmoking area) there were over 50 cigarette butts disposed on the ground around the exit and staff were observed smoking. Also, in the designated smoking area there were over 30 cigarette butts on the ground. Based on interview at the time of observations, the Maintenance Director agreed there were cigarette butts on the ground in the staff smoking area and outside the employee exit. This finding was reviewed with the Administrator and Maintenance Director at the exit conference. 3.1-19(b)	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 and No Smoking signs have been placed in none smoking areas. 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 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 on the designated smoking area	10/15/2024

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			and that the red cans are for cigarette butts only. 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 Executive director/designee will inspect the smoking court yard 3 times a week to ensure staff 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 recommendations to revise the plan of correction as indicated.	