

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/14/2024
FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155799		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING		X3) DATE SURVEY COMPLETED 10/30/2024	
NAME OF PROVIDER OR SUPPLIER APERION 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 APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
K 0000 Bldg. 01	<p>A 2nd Post Survey Revisit (PSR) to the 1st PSR that exited on 09/30/24 for the Life Safety Code Recertification and State Licensure Survey that exited on 08/08/24 was conducted by the Indiana Department of Health in accordance with 42 CFR Subpart 483.90(a).</p> <p>Survey Date: 10/30/24</p> <p>Facility Number: 012809 Provider Number: 155799 AIM Number: 200136580</p> <p>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.</p> <p>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.</p> <p>All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered.</p> <p>Quality Review completed on 10/31/24</p>			K 0000			

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

TITLE

(X6) DATE

Tamera Shirels

ED

11/08/2024

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined other safeguards 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 disclosable 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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K 0741 SS=E Bldg. 01	<p>NFPA 101 Smoking Regulations</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 smoking area and 1 of 1 nonsmoking area 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 emergency exits.</p> <p>Findings include:</p> <p>Based on observation with the Administrator on 10/30/24 at 11:28 a.m., outside the employee exit (a nonsmoking area) there were over 50 cigarette butts disposed on the ground around the exit. Also, in the designated smoking area there were over 30 cigarette butts on the ground and combustible material mixed with cigarettes in the butt-can. Based on interview at the time of observations, the Administrator agreed there were cigarette butts on the ground in the staff smoking area and outside the employee exit.</p> <p>This finding was reviewed with the Administrator at the exit conference.</p> <p>This deficiency was cited on 09/30/24. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>3.1-19(b)</p>		K 0741	<p>Tag number: K 741</p> <p>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.</p> <p>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.</p> <p>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 in-serviced on the designated smoking area and that the red cans are for cigarette butts only.</p> <p>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</p>		11/04/2024	

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			smoking court yard 2 times a day, Monday - Friday, 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.		