	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155799	X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING X3) DATE SURVEY COMPLETED 06/02/2025			
NAME OF P	PROVIDER OR SUPPLIEF	₹		ADDRESS, CITY, STATE, ZIP COD		
APERION	N CARE MARION L	LC		N, IN 46953		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)	(X5) COMPLETION DATE	
E 0000						
Bldg	conducted by the Ir accordance with 42 Survey Date: 06/02 Facility Number: 0 Provider Number: 1 AIM Number: 200 At this Emergency Care Marion LLC v Emergency Prepare Medicare and Medi and Suppliers, 42 C capacity of 70 and 1 of this survey.	/25 12809 155799	E 0000			
K 0000						
Bldg. 01	Licensure Survey w Department of Hea 483.90(a). Survey Date: 06/02 Facility Number: 0 Provider Number: 1 AIM Number: 200 At this Life Safety	12809 155799 136580 Code survey, Aperion Care bund not in compliance with	K 0000			
LABORATOR	Y DIRECTOR'S OR PRO	VIDER/SUPPLIER REPRESENTATIVE'S S	IGNATURE	TITLE	(X6) DATE	
Tamera Sh	nirels		FD		06/16/2025	

Any defiency statement 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 disclodays 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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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155799	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 06/02/2025
	PROVIDER OR SUPPLIER		614 WI	ADDRESS, CITY, STATE, ZIP COD EST 14TH STREET DN, IN 46953	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
K 0222 SS=E Bldg. 01	Life Safety from Fin National Fire Protect Life Safety Code (L Health Care Occupation of the Safety Code). Health Care Occupation of the Safety System with smoke open to the corridor facility has a capaciful of the Safety Code at the time of this All areas where the access were sprinkle facility services were sprinkled facility services were considered by Code and Safety Code of the Safety	residents have customary ered. All areas providing re sprinklered. Inpleted on 06/05/25 In and interview, the facility means of egress for 1 of 2 rere readily accessible for clinical diagnosis requiring measures. Doors within a gress shall not be equipped that requires the use of a tool less side unless otherwise ection 19.2.2.2.4. Door-locking the permitted in accordance this deficient practice could not, staff and visitors if	K 0222	Tag number: K222 I. What corrective action will be accomplished for those residents found to have been affected by the deficient practi Door code is now posted above double the doors in the therap room II. How other residents has the potential to be affected by same deficient practice will be identified and what corrective action(s) will be taken; All like doors have the code posted at the door.	ce; /e y ving the

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Event ID:

JFFY21

Facility ID: 012809

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

PRINTED: 06/18/2025 FORM APPROVED OMB NO. 0938-039

	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155799	(X2) MULTIPLE C A. BUILDING B. WING	O1	(X3) DATE SURVEY COMPLETED 06/02/2025
	PROVIDER OR SUPPLIEF		614 W	ADDRESS, CITY, STATE, ZIP COD EST 14TH STREET DN, IN 46953	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	Operations (DPO) at 12:51 p.m. on 06/02/25, the exit door set to the outside of the facility in the Rehab room was marked as a facility exit with an exit sign. The door could be opened by entering a four digit code at a keypad by the exit door set but the code to open the door set was not posted. Based on interview at 12:51 p.m. on 06/02/25, the DPO agreed the code to release the exit door set to open was not posted at the keypad. These findings were reviewed with the Executive			III. What measures will be into place and what systemic changes will be made to ensuthat the deficient practice doe recur; Maintenance director waudit all doors marked "Exit" whave the code posted.	ire s not vill
	_	e reviewed with the Executive PO during the exit conference.		IV. How the corrective action(s) will be monitored to ensure the deficient practice wont recur i.e., what quality assurance program will be purplace; Maintenance director/designee will audit all doors marked "Exit" 5 times a week for 4 week, 3 times a week for 4 weeks and then weekly months to ensure the posted remains in place. The results of these audits will reviewed in Quality Assurance Meeting monthly x6 months of until an average of 90% compliance or greater is achieved as consecutive months. The Committee will identify any treater or patterns and make recommendations to revise the plan of correction as indicated.	eek for 4 code Il be e r eved QA ends
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas	- Enclosure			
	Based on observation	on and interview, the facility	K 0321	Tag number: K321	06/16/2025

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155799	B. WI	NG		06/02/	
				_			
NAME OF I	PROVIDER OR SUPPLIEF	8			ADDRESS, CITY, STATE, ZIP COD		
					ST 14TH STREET		
APERIO	N CARE MARION L	LC		MARIO	N, IN 46953		
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TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	16	DATE
	failed to ensure 1 of	f over 8 hazardous areas such			I. What corrective action	(s)	
	as soiled linen and	trash collection rooms			will be accomplished for those		
	(exceeding 64 gallo	ons) were separated from other			residents found to have been		
	spaces by smoke resistant partitions and doors.				affected by the deficient practi	ce:	
	Doors shall be self closing or automatic closing in				The door for the hazardous ar		
		2.1.8. This deficient practice			has been fixed and no other		
		residents, staff and visitors in			issues have been noted.		
		Biohazard Storage room near					
	the E Hall nurse's st						
					II. How other residents ha	ving	
	Findings include:				the potential to be affected by	-	
					same deficient practice will be		
	Based on observations with the Director of Plant				identified and what corrective		
	Operations (DPO) a	at 1:31 p.m. on 06/02/25, the			action(s) will be taken; All othe	er	
		Biohazard Storage room by		hazardous areas doors have been			
		tation was equipped with a			checked to ensure all are in go	ood	
		and a positive latching device			working.		
	_	to the door frame but the door					
	failed to fully self-c	close and latch into the door					
	_	to close multiple times. The			III. What measures will be	put	
		r separate 32-gallon capacity			into place and what systemic	•	
		sh carts and a box for red bag			changes will be made to ensu	re	
		terview at 1:31 p.m. on			that the deficient practice does		
		agreed the corridor door to the			recur; Maintenance Superviso		
		room did not fully self-close			was educated on self-closing		
		oor frame when tested to close			automatic closing doors.		
	multiple times.				ğ		
	_						
	These findings were	e reviewed with the Executive			IV. How the corrective		
	Director and the DF	O during the exit conference.			action(s) will be monitored to		
		-			ensure the deficient practice w	/ill	
	3.1-19(b)				not recur i.e., what quality		
					assurance program will be put	into	
					place; Maintenance		
					Supervisor/designee will audit	all	
					hazardous area doors 5xs a w		
					for 4 weeks, 3xs a week for 4		
					weeks and then weekly for 4		
					months.		

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Facility ID: 012809

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PRINTED: 06/18/2025 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED

155799 B. WING 06/02/2025 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER

APERION CARE MARION I.I.C.

614 WEST 14TH STREET

APERIO	N CARE MARION LLC	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		
			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 0363 SS=E	NFPA 101 Corridor - Doors					
Bldg. 01	Based on observation and interview, the facility failed to ensure 1 of over 30 corridor doors to resident sleeping rooms had no impediment to closing and latching into the door frame and would resist the passage of smoke. This deficient practice could affect over 20 residents, staff and visitors in the vicinity of resident sleeping Room E117.	K 0363	Tag number: K363 I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Door wedge was removed.	06/16/2025		
	Findings include: Based on observations with the Director of Plant Operations (DPO) at 1:35 p.m. on 06/02/25, the corridor door to resident sleeping Room E117 was propped in the fully open position with a wedge placed on the floor under the door. Based on interview at 1:35 p.m. on 06/02/25, the DPO agreed the corridor door to resident sleeping Room E117 was propped in the fully open position with a wedge placed on the floor under the door.		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 residents room doors were swept for wedges and all alert residents were reminded that doors cannot be propped open.			
	These findings were reviewed with the Executive Director and the DPO during the exit conference. 3.1-19(b)		III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; Audit was done of all			

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Event ID:

JFFY21

Facility ID: 012809

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

06/18/2025 PRINTED: FORM APPROVED

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3xs a week for 4 weeks and then weekly for 4 months. 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 0374 SS=E Bldg. 01 Barrie Based on record review, observation and interview; the facility failed to ensure 1 of 3 sets of smoke barrier doors would restrict the movement K 0374 K 0374 Tag number: K374 I. What corrective action(s) will be accomplished for those						_		
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X3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. K 0374 SS=E Bldg. 01 Barrie Based on record review, observation and interview; the facility failed to ensure 1 of 3 sets of smoke barrier doors would restrict the movement X 2 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. K 0374 Tag number: K374 I. What corrective action(s) will be accomplished for those						_		
Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. K 0374 SS=E Bldg. 01 Based on record review, observation and interview; the facility failed to ensure 1 of 3 sets of smoke barrier doors would restrict the movement Committee will identify any trends or patterns and make recommends or patterns and make recommends or patterns and make recommendations to revise the plan of correction as indicated. K 0374 Tag number: K374 I. What corrective action(s) will be accomplished for those								
K 0374 SS=E Bldg. 01 Based on record review, observation and interview; the facility failed to ensure 1 of 3 sets of smoke barrier doors would restrict the movement Or patterns and make recommendations to revise the plan of correction as indicated. K 0374 Tag number: K374 I. What corrective action(s) will be accomplished for those								
K 0374 SS=E Bldg. 01 Based on record review, observation and interview; the facility failed to ensure 1 of 3 sets of smoke barrier doors would restrict the movement R 0374 SS=E Bldg. 01 Based on record review, observation and interview; the facility failed to ensure 1 of 3 sets of smoke barrier doors would restrict the movement R 0374 R 0374 Tag number: K374 I. What corrective action(s) will be accomplished for those						1	ndo	
K 0374 SS=E Bldg. 01 NFPA 101 Subdivision of Building Spaces - Smoke Barrie Based on record review, observation and interview; the facility failed to ensure 1 of 3 sets of smoke barrier doors would restrict the movement K 0374 Tag number: K374 I. What corrective action(s) will be accomplished for those						-	Э	
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SS=E Bldg. 01 Based on record review, observation and interview; the facility failed to ensure 1 of 3 sets of smoke barrier doors would restrict the movement K 0374 Tag number: K374 I. What corrective action(s) will be accomplished for those	K 0374	NEPA 101						
Bldg. 01 Barrie Based on record review, observation and interview; the facility failed to ensure 1 of 3 sets of smoke barrier doors would restrict the movement K 0374 Tag number: K374 I. What corrective action(s) will be accomplished for those			ilding Spaces - Smoke					
interview; the facility failed to ensure 1 of 3 sets of smoke barrier doors would restrict the movement I. What corrective action(s) will be accomplished for those			U					
smoke barrier doors would restrict the movement will be accomplished for those				K 03	374	Tag number: K374		06/16/2025
			-					
of smoke for at least 20 minutes. LSC, Section I residents found to have been						•		
19.3.7.8 requires doors in smoke barriers shall affected by the deficient practice;							ce:	

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comply with LSC, Section 8.5.4. LSC, Section

8.5.4.1 requires doors in smoke barriers to close

the opening leaving only the minimum clearance

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The smoke barrier doors were

fixed and no longer have a 1" gap.

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CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 155799 B. WING 06/02/2025 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 614 WEST 14TH STREET APERION CARE MARION LLC **MARION. IN 46953** (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE necessary for proper operation which is defined as 1/8 inch to restrict the movement of smoke. How other residents having This deficient practice could affect over 30 the potential to be affected by the residents in the vicinity of the smoke barrier door same deficient practice will be set by Room D101. identified and what corrective action(s) will be taken; All smoke Findings include: barrier doors were checked to ensure that the doors meet with Based on review of facility blueprint no gap when closed. documentation with the Director of Plant Operations (DPO) at 12:00 p.m. on 06/02/25, the smoke barrier wall by Room D101 was identified as What measures will be put a "1 hour smoke barrier wall". Based on into place and what systemic observations with the DPO at 12:56 p.m. on changes will be made to ensure 06/02/25, the set of corridor smoke barrier doors that the deficient practice does not identified as 2A/2B in the smoke barrier wall by recur: Maintenance director was Room D101 had a one inch gap where the doors educated on assessing the smoke came together in the closed position near the barrier doors to ensure no gaps bottom of the door set. Each door swung in the are present when doors meet. opposite direction but it appeared that the astragal on one of the doors did not continually cover the meeting edge of the door set from the How the corrective top of the door to the bottom of the door. Based action(s) will be monitored to on interview at 12:56 p.m. on 06/02/25, the DPO ensure the deficient practice will agreed the aforementioned corridor smoke barrier not recur i.e., what quality door set had a one inch gap between the meeting assurance program will be put into edges of the door set when the doors were in the place; Maintenance fully closed position. director/designee will audit all smoke barrier doors 5 times a These findings were reviewed with the Executive week for 4 weeks, 3 times a week Director and the DPO during the exit conference. for 4 weeks and then 1 time a week for 4 months 3.1-19(b) 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

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x3 consecutive months. The QA Committee will identify any trends

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155799		JILDING	onstruction 01	(X3) DATE SURVEY COMPLETED 06/02/2025	
	PROVIDER OR SUPPLIER			614 WE	ADDRESS, CITY, STATE, ZIP COD EST 14TH STREET N, IN 46953		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓΕ	(X5) COMPLETION DATE
					or patterns and make recommendations to revise the plan of correction as indicated		
K 0541 SS=E Bldg. 01	Chu Based on observation failed to ensure 1 of maintained in accordance 9.5.1.4 states the roopening shall be sepaccordance with Sepaccordance with Sepaccordance with Sepaccordance of the state of the	on and interview, the facility f 1 laundry chute doors were redance with LSC 9.5. Section om accessing the chute parated from other spaces in ction 8.7.1.1(3) for severe ent practice could affect over nd visitors.	K 0	541	Tag number: 541 I. What corrective actions will be accomplished for those residents found to have been affected by the deficient praction. New fire rated door has been ordered for the laundry chute.	` ,	07/18/2025
	Operations at 1:15 plinen chute door in a vestibule on the first self closing device to resistance rating lab resistance rated for interview at 1:15 p. the fire resistance rated the fire resistance rated to the fire resistance rated the fire resistance rated to the fire resistance rated for interview at 1:15 p. the fire resistance rated for rated for rated for rated for rated for rate	ons with the Director of Plant p.m. on 06/02/25, the soiled the employee entrance at floor was equipped with a but the door had no affixed fire pel indicating it was fire at least 45 minutes. Based on m. on 06/02/25, the DPO agreed ating for the first floor laundry available for review. The reviewed with the Executive PO during the exit conference.			II. How other residents ha the potential to be affected by same deficient practice will be identified and what corrective action(s) will be taken; all othe doors were inspected and profire rated III. What measures will be into place and what systemic changes will be made to ensur that the deficient practice does recur; Maintenance director winserviced on required fire ratin on doors.	er perly put es not as	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>01</u> COMPL		ETED		
		155799	B. W			06/02	
		.00.00		_		00,02	
NAME OF F	PROVIDER OR SUPPLIEF	3			ADDRESS, CITY, STATE, ZIP COD		
TWINE OF I	NO VIDEN ON SOLI EIEI			614 WE	ST 14TH STREET		
APERIO	N CARE MARION L	LC		MARIO	N, IN 46953		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY		DATE
					IV. How the corrective action(s) will be monitored to ensure the deficient practice wonot recur i.e., what quality assurance program will be purplace; Maintenance director/designee will audit fire rated doors monthly to ensure they are properly fire rated. The results of these audits will reviewed in Quality Assurance Meeting monthly x6 months of until an average of 90% compliance or greater is achied x3 consecutive months. The committee will identify any treatment or patterns and make recommendations to revise the plan of correction as indicated.	t into	
K 0712 SS=C Bldg. 01	failed to document	view and interview, the facility all staff who participated in	K 0	712	Tag number: K 712 I. What corrective action	` '	06/16/2025

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quarters. LSC Section 19.7.1.6 requires drills to be

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residents found to have been

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	01	COMPL	
		155799	B. W	ING		06/02/	2025
NAME OF I	PROVIDER OR SUPPLIEF	· }	-		ADDRESS, CITY, STATE, ZIP COD	_	
					EST 14TH STREET		
APERIO	N CARE MARION L	LC		MARIO	N, IN 46953		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		on each shift under varied			affected by the deficient pract		
		ection 19.7.1.8 states employees pancies shall be instructed in			Fire drills were done on 6/10/2	2025.	
	-	res and devices. This deficient					
		residents, staff and visitors.			II. How other residents ha	vina	
	Practice affects all I	estactio, suit uiu visitois.			the potential to be affected by	-	
	Findings include:				same deficient practice will be		
					identified and what corrective		
	Based on review of	Direct Supply TELS Logbook			action(s) will be taken; All sta	ff,	
		ire Drills" documentation with			who participated in the fire dri		
	the Director of Plan	nt Operations (DPO) at 10:49			6/10/2025, signatures were		
	a.m. on 06/02/25, d	ocumentation for fire drills			collected.		
	conducted on each shift for the most recent						
	twelve month period did not include all staff who				III. What measures will be	put	
		are drill. Based on interview at			into place and what systemic		
		2/25, the DPO stated the facility			changes will be made to ensu		
	_	s per day and agreed			that the deficient practice doe		
		fire drills conducted on each			recur; Maintenance director w		
		cent twelve month period did			re-educated on signatures be obtained after each fire drill from	-	
	drill.	f who participated in the fire			all the participants.	OITI	
	dilli.				all the participants.		
	These findings were	e reviewed with the Executive					
	_	O during the exit conference.			IV. How the corrective		
		-			action(s) will be monitored to		
	3.1-19(b)				ensure the deficient practice v	vill	
	3.1-51(c)				not recur i.e., what quality		
					assurance program will be pu	tinto	
					place; Executive		
					director/designee will paperwo		
					after each fire drill times 1 yea	ır to	
					ensure all fire drills are		
					documented correctly.		
					The results of these audits wil	l be	
					reviewed in Quality Assurance		
					Meeting monthly x6 months o		
					until an average of 90%		
					compliance or greater is achie	ved	
					x3 consecutive months. The		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 155799 B. WING 06/02/2025 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 614 WEST 14TH STREET APERION CARE MARION LLC **MARION. IN 46953** (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. K 0920 **NFPA 101** SS=F Electrical Equipment - Power Cords and Bldg. 01 Extens Based on observation and interview, the facility K 0920 Tag number: K920 06/16/2025 failed to ensure 2 of 2 extension cords including What corrective action(s) power strips were not used as a substitute for will be accomplished for those fixed wiring in 1 of 1 equipment rooms in the residents found to have been basement. LSC 19.5.1 requires utilities to comply affected by the deficient practice; with Section 9.1. LSC 9.1.2 requires electrical The un-approved cord was wiring and equipment to comply with NFPA 70, removed immediately from the National Electrical Code, 2011 Edition. NFPA 70, telephone equipment in the Article 400.8 requires that, unless specifically equipment room permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. How other residents having LSC Section 4.5.7 states any building service the potential to be affected by the equipment or safeguard provided for life safety same deficient practice will be shall be designed, installed and approved in identified and what corrective accordance with all applicable NFPA standards. action(s) will be taken; A sweep This deficient practice could affect all residents, of all electrical rooms in the staff and visitors in the facility. building was done to ensure that no un-approved cords were being Findings include: used. Based on observations with the Director of Plant Operations (DPO) at 1:46 p.m. on 06/02/25, a power strip was plugged into a power strip on a What measures will be put rack for telephone equipment in the equipment into place and what systemic room housing the facility's main fire alarm control changes will be made to ensure panel in the basement. Based on interview at 1:46 that the deficient practice does not p.m. on 06/02/25, the DPO agreed daisy chained recur; Maintenance Supervisor power strips were being used as a substitute for was educated on the use of power fixed wiring in the equipment room in the strips and that power strips cannot basement. be plugged into each other.

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155799	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 06/02/2025
	PROVIDER OR SUPPLIER		614 WE	ADDRESS, CITY, STATE, ZIP COD EST 14TH STREET N, IN 46953	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
		e reviewed with the Executive PO during the exit conference.		IV. How the corrective action(s) will be monitored to ensure the deficient practice wonot recur i.e., what quality assurance program will be put place; The Maintenance Supervisor /designee will do weekly sweeps of all electrical room areas in the building to ensure no un-approved cords being used. The results of these audits will reviewed in Quality Assurance Meeting monthly x6 months of until an average of 90% compliance or greater is achie x3 consecutive months. The Committee will identify any treor patterns and make recommendations to revise the plan of correction as indicated e to ensure that the deficient practice does not recur; was educated on no outside cords being used unless approved by Maintenance Supervisor.	are I be e r eved QA ends e
K 0921 SS=F Bldg. 01	interview; the facili required maintenan- documentation of ir Related Electrical E Health Care Faciliti 10.3 and 10.5 states resistance, leakage	riew, observation and ty failed to conduct the ce and maintain complete aspections for all Patient Care Equipment (PCREE). NFPA 99, es Code, 2012 edition, sections the physical integrity, current, and touch current portable PCREE is performed as	K 0921	Tag number: K921 I. What corrective action will be accomplished for those residents found to have been affected by the deficient practi Testing equipment was delive on 6/9/2025.	ice;

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155799	r í	UILDING	onstruction 01	COMPL 06/02	ETED
	PROVIDER OR SUPPLIEI			614 WE	ADDRESS, CITY, STATE, ZIP COD EST 14TH STREET N, IN 46953		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
IAU	required in 10.3. The with policies and propatient care rooms 10.3.5.4 or 10.3.6 be after any repair or a consisting of several demonstrates complete system. So and procedures profincled information are considered in the for electrical equipment instruction are readily available condensed operation appliance are legible equipment tests, reparaintained for a percompliance in accorpolicy. Personnel are maintenance and us receive continuous practice affects all friends include: Based on review of Electrical Equipment dated 02/24/25 with Operations (DPO) applications (DPO) applications (DPO) are testing and on interview at 12.5 stated the facility hequipment and agreed documentation was affected to the same part of the same part o	esting intervals are established rotocols. All PCREE used in its tested in accordance with refore being put into service and modification. Any system all electrical appliances liance with NFPA 99 as a service manuals, instructions, wided by the manufacturer as required by 10.5.3.1.1 and redevelopment of a program ment maintenance. Electrical rons and maintenance manuals reduced and resistance with the facility's responsible for the testing, redefective and appliances training. This deficient residents in the facility. The Personal Care Required residents in the Director of Plant resistance testing, leakage touch current testing. Based as p.m. on 06/02/25, the DPO residents of the testing red completed PCREE testing red red reversible residents with the DPO at		IAU	II. How other residents he the potential to be affected by same deficient practice will be identified and what corrective action(s) will be taken; Testing all patient care related electricequipment was started on 6/10/2025. III. What measures will be into place and what systemic changes will be made to ensure the deficient practice does recur; A log will be kept in a binder in the maintenance off all resident personal care requipment testing (PCREE). IV. How the corrective action(s) will be monitored to ensure the deficient practice not recur i.e., what quality assurance program will be puplace; Executive director/des will audit the PCREE testing times a week for 4 weeks, 3 to a week for 4 weeks and then monthly for 4 months to ensure the test is done correctly. The results of these audits wireviewed in Quality Assurance Meeting monthly x6 months to ensure the deficient practice will an average of 90% compliance or greater is aching the compliance or greater is aching the compliance will identify any trecommittee will identify any trec	aving to the electric the elect	DATE

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155799	A. BUILDING <u>01</u> COMPLETED B. WING 06/02/2025				
NAME OF PROVIDER OR SUPPLIER APERION CARE MARION LLC (X4) ID SUMMARY STATEMENT OF DEFICIENCIE				614 WE	ADDRESS, CITY, STATE, ZIP COD EST 14TH STREET N, IN 46953		
(X4) ID				ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	1:00 p.m. on 06/02/	25, the resident bed in Room			or patterns and make		
	D101 was an electri	ic bed. Based on interview at			recommendations to revise the	Э	
	1:00 p.m. on 06/02/	25, the DPO stated all resident			plan of correction as indicated		
	beds in the facility	are electric beds.					
	_	e reviewed with the Executive PO during the exit conference.					

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