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	06/02/2025

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: 06/02/25 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 62 at the time of this survey. Quality Review completed on 06/05/25	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: 06/02/25 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	06/16/2025

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 62 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 06/05/25			
K 0222 SS=E Bldg. 01	NFPA 101 Egress Doors Based on observation and interview, the facility failed to ensure the means of egress for 1 of 2 Rehab room exits were readily accessible for residents without a clinical diagnosis requiring specialized security measures. Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side unless otherwise permitted by LSC Section 19.2.2.2.4. Door-locking arrangements shall be permitted in accordance with 19.2.2.2.5.2. This deficient practice could affect over 5 residents, staff and visitors if needing to exit the Rehab room. Findings include: Based on observations with the Director of Plant	K 0222	Tag number: K222 I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Door code is now posted above double the doors in the therapy 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; All like doors have the code posted above the door.	06/16/2025

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	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 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; Maintenance director will audit all doors marked “Exit” will have the code posted. 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 marked “Exit” 5 times a week for 4 week, 3 times a week for 4 weeks and then weekly for 4 months to ensure the posted code remains in place. 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 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Based on observation and interview, the facility	K 0321	Tag number: K321	06/16/2025

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	failed to ensure 1 of over 8 hazardous areas such as soiled linen and trash collection rooms (exceeding 64 gallons) were separated from other spaces by smoke resistant partitions and doors. Doors shall be self closing or automatic closing in accordance with 7.2.1.8. This deficient practice could affect over 20 residents, staff and visitors in the vicinity of the Biohazard Storage room near the E Hall nurse's station. Findings include: Based on observations with the Director of Plant Operations (DPO) at 1:31 p.m. on 06/02/25, the corridor door to the Biohazard Storage room by the E Hall nurse's station was equipped with a self-closing device and a positive latching device to latch the door into the door frame but the door failed to fully self-close and latch into the door frame when tested to close multiple times. The room contained four separate 32-gallon capacity soiled linen and trash carts and a box for red bag waste. Based on interview at 1:31 p.m. on 06/02/25, the DPO agreed the corridor door to the Biohazard Storage room did not fully self-close and latch into the door frame when tested to close multiple times. These findings were reviewed with the Executive Director and the DPO 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; The door for the hazardous area has been fixed and no other issues have been noted. 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 other hazardous areas doors have been checked to ensure all are in good working. 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 was educated on self-closing or automatic closing doors. 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 audit all hazardous area doors 5xs a week for 4 weeks, 3xs a week for 4 weeks and then weekly for 4 months.	

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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 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors 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. 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. These findings were reviewed with the Executive Director and the DPO during the exit conference. 3.1-19(b)	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. 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. 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	06/16/2025

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			resident doors and those that will not stay open on their own were adjusted to stay open on their own. 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, 5xs a week for 4 weeks, 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	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 of smoke for at least 20 minutes. LSC, Section 19.3.7.8 requires doors in smoke barriers shall 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	K 0374	Tag number: K374 I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; The smoke barrier doors were fixed and no longer have a 1” gap.	06/16/2025

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	necessary for proper operation which is defined as 1/8 inch to restrict the movement of smoke. This deficient practice could affect over 30 residents in the vicinity of the smoke barrier door set by Room D101. Findings include: Based on review of facility blueprint 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 a "1 hour smoke barrier wall". Based on observations with the DPO at 12:56 p.m. on 06/02/25, the set of corridor smoke barrier doors identified as 2A/2B in the smoke barrier wall by Room D101 had a one inch gap where the doors came together in the closed position near the bottom of the door set. Each door swung in the 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 top of the door to the bottom of the door. Based on interview at 12:56 p.m. on 06/02/25, the DPO agreed the aforementioned corridor smoke barrier door set had a one inch gap between the meeting edges of the door set when the doors were in the fully closed position. These findings were reviewed with the Executive Director and the 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 smoke barrier doors were checked to ensure that the doors meet with no gap when closed. 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 was educated on assessing the smoke barrier doors to ensure no gaps are present when doors meet. 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 smoke barrier doors 5 times a week for 4 weeks, 3 times a week for 4 weeks and then 1 time a week 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	

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			or patterns and make recommendations to revise the plan of correction as indicated.	
K 0541 SS=E Bldg. 01	NFPA 101 Rubbish Chutes, Incinerators, and Laundry Chu Based on observation and interview, the facility failed to ensure 1 of 1 laundry chute doors were maintained in accordance with LSC 9.5. Section 9.5.1.4 states the room accessing the chute opening shall be separated from other spaces in accordance with Section 8.7.1.1(3) for severe hazard. This deficient practice could affect over 10 residents, staff and visitors. Findings include: Based on observations with the Director of Plant Operations at 1:15 p.m. on 06/02/25, the soiled linen chute door in the employee entrance vestibule on the first floor was equipped with a self closing device but the door had no affixed fire resistance rating label indicating it was fire resistance rated for at least 45 minutes. Based on interview at 1:15 p.m. on 06/02/25, the DPO agreed the fire resistance rating for the first floor laundry chute door was not available for review. These findings were reviewed with the Executive Director and the DPO during the exit conference. 3.1-19(b)	K 0541	Tag number: 541 I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; New fire rated door has been ordered for the laundry chute. 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 other doors were inspected and properly fire rated 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 was inserviced on required fire ratings on doors.	07/18/2025

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			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 fire rated doors monthly to ensure they are properly fire rated. 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 0712 SS=C Bldg. 01	NFPA 101 Fire Drills Based on record review and interview, the facility failed to document all staff who participated in quarterly fire drills on each shift for 4 of 4 quarters. LSC Section 19.7.1.6 requires drills to be	K 0712	Tag number: K 712 I. What corrective action(s) will be accomplished for those residents found to have been	06/16/2025

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	conducted quarterly on each shift under varied conditions. LSC Section 19.7.1.8 states employees of health care occupancies shall be instructed in life safety procedures and devices. This deficient practice affects all residents, staff and visitors. Findings include: Based on review of Direct Supply TELS Logbook Documentation: "Fire Drills" documentation with the Director of Plant Operations (DPO) at 10:49 a.m. on 06/02/25, documentation for fire drills conducted on each shift for the most recent twelve month period did not include all staff who participated in the fire drill. Based on interview at 10:49 a.m. on 06/02/25, the DPO stated the facility operates three shifts per day and agreed documentation for fire drills conducted on each shift in the most recent twelve month period did not include the staff who participated in the fire drill. These findings were reviewed with the Executive Director and the DPO during the exit conference. 3.1-19(b) 3.1-51(c)		affected by the deficient practice; Fire drills were done on 6/10/2025. 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, who participated in the fire drills on 6/10/2025, signatures were collected. 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 was re-educated on signatures being obtained after each fire drill from all the participants. 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; Executive director/designee will paperwork after each fire drill times 1 year to ensure all fire drills are documented correctly. 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	

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			Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	
K 0920 SS=F Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Based on observation and interview, the facility failed to ensure 2 of 2 extension cords including power strips were not used as a substitute for fixed wiring in 1 of 1 equipment rooms in the basement. LSC 19.5.1 requires utilities to comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 2011 Edition. NFPA 70, Article 400.8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. LSC Section 4.5.7 states any building service equipment or safeguard provided for life safety shall be designed, installed and approved in accordance with all applicable NFPA standards. This deficient practice could affect all residents, staff and visitors in the facility. Findings include: 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 rack for telephone equipment in the equipment room housing the facility's main fire alarm control panel in the basement. Based on interview at 1:46 p.m. on 06/02/25, the DPO agreed daisy chained power strips were being used as a substitute for fixed wiring in the equipment room in the basement.	K 0920	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 removed immediately from the telephone equipment in the equipment 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 electrical rooms in the building was done to ensure that no un-approved cords were being used. 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 was educated on the use of power strips and that power strips cannot be plugged into each other.	06/16/2025

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	These findings were reviewed with the Executive Director and the DPO during the exit 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; The Maintenance Supervisor /designee will do weekly sweeps of all electrical room 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. e to ensure that the deficient practice does not recur; was educated on no outside cords being used unless approved by the Maintenance Supervisor.	
K 0921 SS=F Bldg. 01	NFPA 101 Electrical Equipment - Testing and Maintenanc Based on record review, observation and interview; the facility failed to conduct the required maintenance and maintain complete documentation of inspections for all Patient Care Related Electrical Equipment (PCREE). NFPA 99, Health Care Facilities Code, 2012 edition, sections 10.3 and 10.5 states the physical integrity, resistance, leakage current, and touch current tests for fixed and portable PCREE is performed as	K 0921	Tag number: K921 I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Testing equipment was delivered on 6/9/2025.	06/16/2025

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	required in 10.3. Testing intervals are established with policies and protocols. All PCREE used in patient care rooms is tested in accordance with 10.3.5.4 or 10.3.6 before being put into service and after any repair or modification. Any system consisting of several electrical appliances demonstrates compliance with NFPA 99 as a complete system. Service manuals, instructions, and procedures provided by the manufacturer include information as required by 10.5.3.1.1 and are considered in the development of a program for electrical equipment maintenance. Electrical equipment instructions and maintenance manuals are readily available, and safety labels and condensed operating instructions on the appliance are legible. A record of electrical equipment tests, repairs, and modifications is maintained for a period of time to demonstrate compliance in accordance with the facility's policy. Personnel responsible for the testing, maintenance and use of electrical appliances receive continuous training. This deficient practice affects all residents in the facility. Findings include: Based on review of "Personal Care Required Electrical Equipment Testing" documentation dated 02/24/25 with the Director of Plant Operations (DPO) at 12:35 p.m. on 06/02/25, PCREE testing documentation was incomplete. The 02/24/25 PCREE testing documentation did not include electrical resistance testing, leakage current testing and touch current testing. Based on interview at 12:35 p.m. on 06/02/25, the DPO stated the facility has ordered PCREE testing equipment and is awaiting delivery of the testing equipment and agreed completed PCREE testing documentation was not available at the time of the survey. Based on observations with the DPO at		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; Testing on all patient care related electrical equipment was started on 6/10/2025. III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; A log will be kept in a binder in the maintenance office of all resident personal care required electrical equipment testing (PCREE). 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; Executive director/designee will audit the PCREE testing log 5 times a week for 4 weeks, 3 times a week for 4 weeks and then monthly for 4 months to ensure test is done correctly. 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	

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	06/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	1:00 p.m. on 06/02/25, the resident bed in Room D101 was an electric bed. Based on interview at 1:00 p.m. on 06/02/25, the DPO stated all resident beds in the facility are electric beds. These findings were reviewed with the Executive Director and the DPO during the exit conference. 3.1-19(b)		or patterns and make recommendations to revise the plan of correction as indicated.	