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	02/13/2019

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 State Department of Health in accordance with 42 CFR 483.73. Survey Date: 2/13/19 Facility Number: 012809 Provider Number: 155799 AIM Number: 200136580 At this Emergency Preparedness survey, Aperion Care Marion LLC was found in substantial 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 54 at the time of this survey. Quality Review completed on 02/18/19 The requirement at 42 CFR, Subpart 483.73 is NOT MET as evidenced by:	E 0000	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	
E 0013 SS=C Bldg. --	Based on record review and interview, the facility failed to develop and implement emergency preparedness policies and procedures based on a facility and community based risk assessment utilizing an all-hazards approach. The policies and procedures must be reviewed and updated at least annually in accordance with 42 CFR 483.73(b). This deficient practice could affect all residents in the facility. Findings include:	E 0013	**E013 - Emergency Preparedness** **The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not*	05/03/2019

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
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	Based on review of the facility's Emergency Preparedness Plan (EPP) with the Assistant Director of Nursing and Maintenance Director on 02/13/19 at 10:30 a.m., the provided EPP contained policies and procedures not based on the facility's risk assessment. Several policies in the EPP were titled "Aperion Care Peru Emergency Operation Plan" which were developed for another facility, not Aperion Care of Marion. Based on interview at the time of record review, the Assistant Director of Nursing and Maintenance Director agreed there were some polices written for another facility in the provided EPP.		*constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** Policies involved with Emergency Preparedness for Aperion Care Marion were revised and reviewed. **2) How the facility identified other residents:** All residents could have been affected; No Residents were affected. **3) Measures put into place/ System changes:** Staff were in-serviced on the Emergency Preparedness Policy Staff completed a post test for understanding of policy. **4) How the corrective actions will be monitored:** . Will continue to educate employees annually and upon hire on the	

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			facility's EEP. Any new additions will be put into binder and staff will receive education. Executive Director is responsible for oversight. Policy will be reviewed with Medical Director for said compliance. To QA monthly x6 months and quarterly thereafter, or until deemed unnecessary. 5) 05/03/2019	
E 0015 SS=C Bldg. --	Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include at a minimum, (1) The provision of subsistence needs for staff and residents, whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical, and pharmaceutical supplies. (ii) Alternate sources of energy to maintain - (A) Temperatures to protect resident health and safety and for the safe and sanitary storage of provisions; (B) Emergency lighting; (C) Fire detection, extinguishing, and alarm systems; and (D) Sewage and waste disposal in accordance with 42 CFR 483.73(b)(1). This deficient practice could affect all occupants. Findings include: Based on review of the facility's Emergency Preparedness Plan (EPP) with the Assistant Director of Nursing and Maintenance Director on 02/13/19 at 10:40 a.m., the subsistence needs documentation for the emergency preparedness	E 0015	**E015- Temperatures – Cold Weather** **The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:**	05/03/2019

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	program was incomplete. Documentation for temperatures to protect resident health and safety included a policy on hot temperatures but did not include a policy on cold temperatures. Based on interview at the time of records review and during exit conference, the Assistant Director of Nursing and Maintenance Director stated the provided EPP did not contain a policy addressing cold temperatures.		The facility policy was updated to include temperatures for the cold weather. **2) How the facility identified other residents:** All residents could be affected; facility has had No negative outcomes. **3) Measures put into place/ System changes:** Staff will be in-serviced on the Code White Policy and updated policy will be placed at nurses' stations for accessibility to staff. Executive Director will be responsible for oversight. **4) How the corrective actions will be monitored:** . The results of the training will be reviewed in QA for 6 month or deemed unnecessary by the QAA. Any recommendations will be followed. **5) Date of compliance:** **05/03/2019**	
E 0023 SS=C Bldg. --	Based on record review and interview, the facility	E 0023	**E023- EMR Procedure**	05/03/2019

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	failed to ensure emergency preparedness policies and procedures include a system of medical documentation that preserves resident information, protects confidentiality of resident information, and secures and maintains the availability of records in accordance with 42 CFR 483.73(b)(4). This deficient practice could affect all occupants. Findings include: Based on review of the facility's Emergency Preparedness Plan (EPP) with the Assistant Director of Nursing and Maintenance Director on 02/13/19 at 10:30 a.m., the provided (EPP) did not contain documentation to indicate the use of a system to preserve resident medical documentation during an emergency. Based on interview at the time of record review then again at the exit conference, the Assistant Director of Nursing was unable to find a policy on a system to preserve resident medical documentation in the provided EPP.		**The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** Policy was in Manual and was reviewed. **2) How the facility identified other residents:** All residents could be affected; no residents have had negative outcome **3) Measures put into place/ System changes:** Staff will be in-serviced on the Emergency Electronic Medical Records. This policy will remain in Emergency Preparedness Manual.	

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			Executive Director Is responsible for oversight. **4) How the corrective actions will be monitored:** . The results of the training will be reviewed in QA for 6 months or deemed unnecessary by the QAA. Any recommendations will be followed. **5) Date of compliance:** 05/03/2019	
E 0024 SS=C Bldg. --	Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include the use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State or Federally designated health care professionals to address surge needs during an emergency in accordance with 42 CFR 483.73(b)(6). This deficient practice could affect all occupants. Findings include: Based on review of the facility's Emergency Preparedness Plan (EPP) with the Assistant Director of Nursing and Maintenance Director on 02/13/19 at 11:10 a.m., the provided EPP did not address the use of volunteers in an emergency. Based on interview at the time of records review and during exit conference, the Assistant Director of Nursing stated there was a policy on the use of	E 0024	**E024- Volunteers** **The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	05/03/2019

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	volunteers in an emergency but was unable to find and provide the policy.		**1) Immediate actions taken for those residents identified:** Policy was located and reviewed and placed in all manuals. **2) How the facility identified other residents:** All residents and volunteers could be affected; there has been no negative outcome to residents, and volunteers. **3) Measures put into place/ System changes:** Staff will be in-serviced on the Volunteer Policy, Staff and Volunteer Utilization Logs Updated policy will be placed at all nurses' stations for accessibility to staff. Executive Director will be responsible for oversight . **4) How the corrective actions will be monitored:** . The results of the training will be reviewed in QA for 6 months or deemed unnecessary by the QAA. Any recommendations will be followed. **5) Date of compliance: 05/03/2019**	

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E 0034 SS=C Bldg. --	Based on record review and interview, the facility failed to ensure the emergency preparedness communication plan includes a means of providing information about the LTC facility's occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction or the Incident Command Center, or designee in accordance with 42 CFR 483.73(c)(7). This deficient practice could affect all occupants. Findings include: Based on review of the facility's Emergency Preparedness Plan (EPP) with the Assistant Director of Nursing and Maintenance Director on 02/13/19 at 11:30 a.m., the provided EPP communication plan did not address a means of providing information about the LTC facility's occupancy, needs, and its ability to provide assistance to the authority having jurisdiction or the Incident Command Center, or designee. Based on interview at the time of records review and during exit conference, the Assistant Director of Nursing looked through the EPP and could not find a plan that address a means of providing information about the LTC facility's occupancy, needs, and its ability to provide assistance.	E 0034	**K 0034 Occupancy Needs** **The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** Facility Emergency EPP was reviewed and revised to add means of providing information about the LTC facility's occupancy needs and its ability to provide assistance. **2) How the facility identified other residents:** All residents have the potential to be affected By this deficient practice. No negative outcome to Staff, visitors and or residents.	05/03/2019

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			3) Measures put into place/ System changes: Executive Director will oversee that policies are reviewed and revised annually and as deemed necessary. Executive Director will be responsible to in-service staff on updates made to plan. **4) How the corrective actions will be monitored:** . The results of these will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance 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. **5) Date of compliance:** 05/03/2019	
E 0037 SS=C Bldg. --	Based on record review and interview, the facility failed to maintain complete documentation of training for the Emergency Preparedness Program (EPP). The LTC facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services	E 0037	**E037 – Emergency Preparedness** **The facility requests paper compliance for this citation.** *This Plan of Correction is the*	05/03/2019

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	under arrangement, and volunteers, consistent with their expected roles; (ii) Provide emergency preparedness training at least annually; (iii) Maintain documentation of the training; (iv) Demonstrate staff knowledge of emergency procedures in accordance with 42 CFR 483.73(d)(1). This deficient practice could affect all residents in the facility. Findings include: Based on review of the facility's Emergency Preparedness Plan (EPP) with the Assistant Director of Nursing and Maintenance Director on 02/13/19 at 10:10 a.m., there was documentation of a sign sheet for EPP training; but there was no documentation to show staff could demonstrate knowledge of the EPP. Based on an interview at the time of records review, the Assistant Director of Nursing and Maintenance Director stated all staff have been trained on the EPP in the last year but there was no documentation to show staff could demonstrate knowledge of the EPP.		*center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** Staff re in-serviced and given a test to show knowledge of the EEP. **2) How the facility identified other residents:** All residents could be affected; no negative outcome to residents **3) Measures put into place/ System changes:** Staff in-serviced on the EEP and given a test to demonstrate their knowledge of the EEP. Will continue to educate on the EEP upon hire and annually and will include a test so employee can demonstrate their knowledge. Executive Director will be	

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			responsible for oversight. **4) How the corrective actions will be monitored:** . The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until deemed unnecessary. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **5) Date of compliance:** 05/03/2019	
E 0039 SS=C Bldg. --	1. Based on record review and interview, the facility failed to document its inability to identify a full-scale community based exercise to test the emergency plan at least annually. The LTC facility must do all of the following: (i) participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual, facility-based. If the LTC facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging in a community-based or individual, facility-based full-scale exercise for 1 year following the onset of the actual event; (ii) conduct an additional exercise that may include, but is not limited to the following: (A) a second	E 0039	**E039- Emergency Preparedness Drills** **The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of*	05/03/2019

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	full-scale exercise that is community-based or individual, facility-based. (B) a tabletop exercise that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the LTC facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the facility's emergency plan, as needed in accordance with 42 CFR 483.73(d)(2). This deficient practice could affect all occupants. Findings include: Based on record review with the Assistant Director of Nursing and Maintenance Director on 02/13/19 at 10:32 a.m., there was documentation of six facility based exercises in the last year, but there was no documentation of a community based exercise within the last year. In addition, there was no documentation of an attempt to contact any area Health Care Coalitions (HCC) or State or Local emergency officials for participation in a community based emergency preparedness exercise. Based on interview at the time of records review, the Assistant Director of Nursing and Maintenance Director stated no documentation of a community based exercise could be provided or of an attempt to schedule one within the community. 2. Based on record review and interview, the facility failed to analyze the LTC facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the LTC facility's Emergency Preparedness Plan (EPP). The LTC facility is		*deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** Evacuation of residents has been scheduled for March 11, 2019 with the Fire Department. **2) How the facility identified other residents:** All residents could be affected; No residents have had Any negative outcome. **3) Measures put into place/ System changes:** EEP officers will be in-serviced on analyzing drills to ensure the facility's response and EEP effective/ Improvement needed. The Executive Director or Designee will audit each drill to ensure that each drill was analyzed, and facility's response was effective. **4) How the corrective actions will be monitored:** . The results of these audits will be reviewed in Quality Assurance	

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	required to analyze the LTC facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the facility's emergency plan, as needed in accordance with 42 CFR 483.73(d)(2). This deficient practice could affect all occupants. Findings include: Based on record review with the with the Assistant Director of Nursing and Maintenance Director on 02/13/19 at 10:32 a.m., documentation for the conducted EEP facility based exercises for the past 12 months were incomplete. No documentation was provided to show the exercises were analyzed to ensure the facility's response and EPP were effective. Based on interview at the time of records review, the Maintenance Director stated the scenario for the exercises were documented but no documentation for analyzing the LTC facility's response could be provide.		Meeting monthly for 6 months or until 100% compliance 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. **5) Date of compliance: 05/03/2019**	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 2/13/19 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	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of*	

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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 54 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 02/18/19		*federal and state law.*	
K 0211 SS=E Bldg. 01	NFPA 101 Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 Based on observation and interview, the facility failed to ensure 1 of 8 corridor means of egresses were continuously maintained free of obstructions. This deficient practice affects 20 residents. Findings include: Based on an observation during a tour of the	K 0211	**K 211- Means of Egress** **The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.*	05/03/2019

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APERION CARE MARION LLC	614 WEST 14TH STREET MARION, IN 46953

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	facility with the Maintenance Director 02/13/19 at 12:30 p.m., in the E resident hall by room 126 there was a stationary wooden paper disposal box against the wall protruding into the eight foot corridor about two feet. Based on an interview at the time of observations, the Maintenance Director stated the paper disposal box was in the corridor and will be moved. 3.1-19(b)		*Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified: Stationary wooden paper disposal box was immediately removed by E126 room. (E Hall).** **2) How the facility identified other residents: All 20 residents have the potential to be affected by this deficient practice. There was no negative outcome for door obstruction.** **3) Measures put into place/ System changes: Staff will be in-serviced on Means of Egress Will be added to daily maintenance PM Log. Executive Director will round 2x weekly with maintenance To ensure compliance. Any non-compliance will be Noted and immediately**	

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			corrected. **4) How the corrective actions will be monitored:** . The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance 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. **5) Date of compliance:** 05/03/2019	
K 0221 SS=F Bldg. 01	NFPA 101 Patient Sleeping Room Doors Patient Sleeping Room Doors Locks on patient sleeping room doors are not permitted unless the key-locking device that restricts access from the corridor does not restrict egress from the patient room, or the locking arrangement is permitted for patient clinical, security or safety needs in accordance with 18.2.2.2.5 or 19.2.2.2.5. 18.2.2.2, 19.2.2.2, TIA 12-4 Based on observation, the facility failed to ensure 66 of 66 resident room doors containing locks could be readily unlocked in accordance with LSC 19.2.2.2.6 which allows doors that are located in the means of egress and are permitted to be locked under other provisions of 19.2.2.2.5 shall comply with the following. (1) Provisions shall be	K 0221	**K 221** **The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of*	05/03/2019

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	made for the rapid removal of occupants by means of one of the following: (a) Remote control of locks (b) Keying of all locks to keys carried by staff at all times (c) Other such reliable means available to the staff at all times. This deficient practice could affect all residents. Findings include: Based on observations during a tour of the facility with the Maintenance Director on 02/13/19 between 11:40 a.m. and 3:30 p.m., all resident room corridor doors in E and D halls contained a door handle equipped with a key lock. The only available key was the key the Maintenance Director had and a key that is kept in the Assisted Living (AL) Hall. Based on interview at the time of observation, Registered Nurse #1 (RN) stated facility leadership has a key to all the room but a key was not carried by staff on the D and E halls. RN #2 stated at night if a door needs to be unlocked they would have to leave there hall go to the AL hall get the key and then return to the hall to unlock the door. The Maintenance Director agreed all resident room doors had locks and the facility was working on getting new keys for staff. 3.1-19(b)		*compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** Maintenance is working with locksmith on obtaining copies of keys. **2) How the facility identified other residents:** All residents have the potential to be affected by this deficient practice. A key is in facility for emergencies. No negative outcomes have occurred. **3) Measures put into place/ System changes:** Executive Director/ Designee will ensure compliance 1x weekly by checking with Nursing Managers. Keys will be replaced as deemed necessary **4) How the corrective**	

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			actions will be monitored: . The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance 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. **5) Date of compliance:** **05/03/2019**	
K 0222 SS=E Bldg. 01	NFPA 101 Egress Doors Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the			

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	safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system.			

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	18.2.2.2.4, 19.2.2.2.4 Based on observation and interview, the facility failed to ensure the means of egress through 1 of 12 delayed egress locks was readily accessible for all residents, staff, and visitors. LSC 7.2.1.6.1.(3)(4) states a readily visible, durable sign in letters not less than 1 in. (25mm) high and not less than 1/8 in. (3.2mm) in stroke width on a contrasting background that reads as follows shall be located on the door leaf adjacent to the release device in the direction of egress: "PUSH UNTIL ALARM SOUNDS. DOOR CAN BE OPENED IN 15 SECONDS". This deficient practice could affect 50 residents form the 300 and 100 halls that would use the breezeway exit. Findings include: Based on observations during tour of the facility with the Maintenance Director on 02/13/19 at 12:35 p.m., the front lobby exit door way provided with delayed egress locks but lacked the proper signage indicating the doors can be opened in 15 seconds by pushing on the door. Based on interview at the time of observation, the Maintenance Director acknowledged the door was equipped with a delayed egress and lacked the proper signage. 3.1-19(b)	K 0222	**K222 Egress Doors** **The facility requests paper compliance for this citation.** This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. **1) Immediate actions taken for those residents identified:** The facility posted the code next to the door that residents would use for the breezeway exit. Signage for front lobby door equipped with a delayed egress has been ordered. **2) How the facility identified other residents:** All resident could be affected, no resident has had negative outcome. **3) Measures put into place/ System changes:**	05/03/2019

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			Maintenance director/designee will make monthly checks to ensure all doors requiring a 15 second signage are on doors. Executive director /designee will complete rounds with maintenance director/to ensure compliance. Rounds will be added to monthly maintenance log. **4) How the corrective actions will be monitored:** Maintenance Director will bring results to QAA meeting for 6 months and quarterly thereafter if 100% complaint. **5) Date of compliance:** 05/03/2019	
K 0232 SS=E Bldg. 01	NFPA 101 Aisle, Corridor, or Ramp Width Aisle, Corridor or Ramp Width 2012 EXISTING The width of aisles or corridors (clear or unobstructed) serving as exit access shall be at least 4 feet and maintained to provide the convenient removal of nonambulatory patients on stretchers, except as modified by 19.2.3.4, exceptions 1-5. 19.2.3.4, 19.2.3.5 Based on observation, the facility failed to meet the clear width requirement for 2 of 8 corridors or met an exception per 19.2.3.4(5). LSC 19.2.3.4(5) states where the corridor width is at least 8 feet, projections into the required width shall be permitted for fixed furniture, provided that all of the following conditions are met: (a) the fixed furniture is securely attached to the floor or to the wall.	K 0232	**K 232** **The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.*	05/03/2019

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	(b) the fixed furniture does not reduce the clear unobstructed corridor width to less than six feet, except as permitted by 19.2.3.4(2). (c) the fixed furniture is located only on one side of the corridor. (d) the fixed furniture is grouped such that each grouping does not exceed an area of 50 square feet. (e) the fixed furniture groupings addressed in 19.2.3.4(5) (d) are separated from each other by a distance of at least 10 feet. (f) the fixed furniture is located so as to not obstruct access to building service and fire protection equipment. (g) corridors throughout the smoke compartment are protected by an electrically supervised automatic smoke detection system in accordance with 19.3.4, or the fixed furniture spaces are arranged and located to allow direct supervision by the facility staff from a nurse's station or similar space. (h) the smoke compartment is protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.8 This deficient practice could affect 35 residents. Findings include: Based on observations during a tour of the facility with the Director of Maintenance on 02/13/18 from 11:35 a.m. to 1:20 p.m., the E hall corridor and the corridor to the AL hall each measured eight feet in clear width. There was one bench in each of the two corridors. Each bench extended about two feet into the corridor and were not affixed to the floor or to the wall when tested. Based on interview at the time of the observations, the Director of Maintenance acknowledged furniture was in the aforementioned two corridors which were not affixed to the floor or to the wall.		*Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** Bench on AL and E Hall were immediately removed **2) How the facility identified other residents:** Residents have the potential to be affected for removal of non-ambulatory on stretchers to corridors / aisles if obstructed. No negative outcome has occurred. **3) Measures put into place/ System changes:** Daily checks will be added to Daily Maintenance Logs. During morning rounds 5 x weekly by Executive Director/ Designee. Corridor's / Aisles will be monitored for compliance. Staff in-service will be completed on obstructing halls with benches. .	

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	3.1-19(b)		**4) How the corrective actions will be monitored:** . The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance 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. **5) Date of compliance: 05/03/2019**	
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9			

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	Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) Based on observation and interview, the facility failed to ensure the corridor doors to 1 of 1 paint storage rooms which is a hazardous area containing combustible liquids was provided with a self-closing device which would cause the door to automatically close and latch into the door frame. This deficient practice could staff in the basement. Findings include: Based on observations during a tour of the facility with the Maintenance Director on 02/13/19 at 3:05 p.m., the paint store room, which stored different types of paint including aerosol paints, contained a self-closing door but there was a magnet over the latch hole preventing the door from latching into the frame. Based on interview at the time of observation, the Maintenance Director agreed the room was used for paint storage and removed the magnet so the door would latch. 3.1-19(b)	K 0321	**K 321 – Hazardous Areas/ Enclosure** **The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is p repared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** Maintenance removed the magnet from self-closing	05/03/2019

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			door latch immediately. **2) How the facility identified other residents:** Residents /Staff have the potential to be affected by this deficient practice. Deficient practice was corrected with Life Safety Surveyor present. **3) Measures put into place/ System changes:** All self-latching doors will be checked in basement to ensure no magnets are placed on door to prevent door (s) from latching into frame. Self-locking Door Monitoring for magnets placed on latches will be added to weekly Maintenance PM Logs. Maintenance/ Designee will complete rounds weekly to ensure compliance. Staff to in-serviced on no magnets allowed on doors. **4) How the corrective actions will be monitored:** . The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance 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.	

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			5) Date of compliance: 05/03/2019	
K 0324 SS=D Bldg. 01	NFPA 101 Cooking Facilities Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 Based on observation and interview, the facility failed to ensure staff were instructed in the use of the UL 300 hood system in 1 of 1 Kitchen. NFPA 96, 11.1.4 states instructions for manually operating the fire extinguishing system shall be posted conspicuously in the kitchen and shall be reviewed with employees by management. This deficient practice could affect staff in the basement.	K 0324	**K 324** **The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of*	05/03/2019

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	Findings include: Based on observation with the Maintenance Director on 02/13/19 at 3:14 p.m., the kitchen contained a UL 300 hood system and a K-class fire extinguisher with posted instructions. Based on interview, the Dining Service employee was asked; what is the correct response if there was a grease fire underneath the hood. The employee replied; would use the hood pull station activation then grab the ABC fire extinguisher. The employee failed to indicate using the correct fire extinguisher for a hood grease fire. Based on interview, the Maintenance Director acknowledged the response and confirmed all kitchen staff will be informed on proper response. 3.1-19(b)		*this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** Dietary Employee was in-serviced on types of Extinguishers / Usage of K extinguisher for hood grease fire. **2) How the facility identified other residents:** All staff/ residents/ visitors have the potential to be Affected by this deficient practice. **3) Measures put into place/ System changes:** Staff will be re in-serviced by Koorsen 02/28/2019. Instructions for operation use of K Extinguisher will be posted in Dietary Department. Dietary Manager / Designee will be responsible for dietary education on extinguishers yearly. **4.) How the corrective actions will be monitored:** Executive Director/ Designee will	

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			randomly x1 weekly ask dietary staff what types of extinguishers are used for a hood grease fire. Any staff found to answer incorrectly will be immediately re-in serviced. Dietary Manager/ Designee will provide in-service for all dietary new employees and all staff annually. . The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance 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. **4) Date of compliance:** 05/03/2019	
K 0331 SS=E Bldg. 01	NFPA 101 Interior Wall and Ceiling Finish Interior Wall and Ceiling Finish 2012 EXISTING Interior wall and ceiling finishes, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and have a flame spread rating of Class A or Class B. The reduction in class of interior finish for a sprinkler system as prescribed in 10.2.8.1 is permitted. 10.2, 19.3.3.1, 19.3.3.2 Indicate flame spread rating(s).			

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	Based on observation and interview, the facility failed to ensure materials used as an interior finish on 2 of 2 canopies and 1 of 1 wood pergolas had a flame spread rating of Class A or Class B in accordance with 19.3.3.1. LSC 101 10.2.3.4 states products required to be tested in accordance with ASTM E 84, Standard Test Method for Surface Burning Characteristics of Building Materials or ANSI/UL 723, Standard for Test for Surface Burning Characteristics of Building Materials shall be grouped in the following classes in accordance with their flame spread and smoke development. (a) Class A Interior Wall and Ceiling Finish. Flame spread 0-25; smoke development 0-450. Includes any material classified at 25 or less on the flame spread test scale and 450 or less on the smoke test scale. Any element thereof, when so tested, shall not continue to propagate fire. (b) Class B Interior Wall and Ceiling Finish. Flame spread 26-75; smoke development 0-450. Includes any material classified at more than 25 but not more than 75 on the flame spread test scale and 450 or less on the smoke test scale. (c) Class C Interior Wall and Ceiling Finish. Flame spread 76-200; smoke development 0-450. Includes any material classified at more than 75 but not more than 200 on the flame spread test scale and 450 or less on the smoke test scale. This deficient practice could affect 30 residents in the front dining room and main hall. Findings include: Based on observation with the Director of Maintenance on 02/13/19 at 12:23 p.m., in the main hall there was a wood pergola and two cloth canopies. Based on records review at exit and via an e-Mail, there was a flame spread documentation for the rating of interior	K 0331	**K331 – Interior Wall and Ceiling Finish** **The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** The facility has the Flamex PF Product Data Sheet for canopies. Canopies were sprayed 04/17/12. Interior Fire-Retardant Spray for unfinished lumber ordered for wood in dining room. **2) How the facility identified other residents:** All residents could be affected, residents/ visitors and or staff Have had any negative outcome. **Measures put into place/ System changes:** Facility will continue to look at	05/03/2019

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	furnishings but it did not state if this included the wood pergola and two cloth canopies. Based on interview at the time of each observation, the Director of Maintenance unable to provide interior finish documentation for a flame spread classification of Class A or B for the aforementioned interior finishes. 3.1-19(b)		interior design for any non-compliance and address immediately **3) How the corrective actions will be monitored:** . The results of these concerns will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance 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. **5) Date of compliance: 05/03/2019**	
K 0346 SS=C Bldg. 01	NFPA 101 Fire Alarm System - Out of Service Fire Alarm - Out of Service Where required fire alarm system is out of services for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.6 Based on record review and interview, the facility failed to provide 1 of 1 correct written policies for the protection of residents indicating procedures to be followed in the event the fire alarm system has to be placed out of service for four hours or	K 0346	**K 346** **The facility requests paper compliance for this citation.**	05/03/2019

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	more in a twenty four hour period in accordance with LSC, Section 9.6.1.6. This deficient practice affects all occupants. Findings include: Based on records review with the Maintenance Director and Assistant Director of Nursing on 02/13/19 at 10:52 a.m., the facility provided fire watch plan documentation but it was not for the Marion facility. There were two different fire watches provided; one from the previous owners and one from the current owners. The provided fire watch from the current owners was reviewed. All contact numbers, such as the fire department, was for the Peru facility and not the Marion facility. Also, the plan failed to include contacting the Indiana State Department of Health via the ISDH Gateway link at https://gateway.isdh.in.gov as the primary method or by the secondary method when the ISDH Gateway is nonoperational by completing the Incident Reporting form and e-mailing it to incidents@isdh.in.gov. The plan just stated "ISDH Gateway/e-mail" Based on interview during the record review, the Maintenance Director and Assistant Director of Nursing acknowledged the fire watch documentation provided was the current policy, contained the wrong phone numbers and only stated ISDH Gateway/e-mail, not the complete ISDH Gateway link or at the e-mail address listed above. 3.1-19(b)		*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** The Fire watch policy has been updated for Aperion Marion, Including the ISDH Gateway Link, https://gateway.isdh.in.gov and Secondary Method incidents@isdh.in.gov **2) How the facility identified other residents:** All residents have the potential to be affected By this deficient practice. No residents have been affected by this deficient practice. **3) Measures put into place/ System changes:** Policy will be reviewed annually for compliance Responsibility of Maintenance	

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			Director with oversight Of Executive Director. Executive Director will In-service management staff on addition notification policy. Policy will be added to Fire Policy Manual. **4) How the corrective actions will be monitored:** . The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance 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. **5) Date of compliance: 05/03/19**	
K 0351 SS=E Bldg. 01	NFPA 101 Sprinkler System - Installation Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific			

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	areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) Based on observation and interview, the facility failed to ensure the spray pattern for sprinkler heads were not obstructed in 4 of 4 closets and 1 of 8 corridors in accordance with 19.3.5.1. NFPA 13, 2010 edition, Section 8.5.5.1 states sprinklers shall be located so as to minimize obstructions to discharge as defined in 8.5.5.2 and 8.5.5.3 or additional sprinklers shall be provided to ensure adequate coverage of the hazard. Sections 8.5.5.2 and 8.5.5.3 do not permit continuous or noncontinuous obstructions less than or equal to 18 inches below the sprinkler deflector or in a horizontal plane more than 18 inches below the sprinkler deflector that prevent the spray pattern from fully developing. This deficient practice could up to 30 residents. Findings include: A) Based on observation with the Maintenance Director on 02/13/19 from 11:35 a.m. to 3:20 p.m., the closets in rooms E129, E118, E137 and E130 had storage touching or within a 4 inches of the sprinkler. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned sprinkler heads were obstructed and did move some of the items. B) Based on observation with the Maintenance Director on 02/13/19 at 1:48 p.m., there was a	K 0351	**K 351- Obstruction** **The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** The closets in rooms E129, E118, E137, and E130 had storage near/touching sprinkler were moved immediately.	05/03/2019

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	hanging pendant sprinkler head within one inch from where the ceiling dropped below the sprinkler head and obstructed the spray pattern on one side. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned sprinkler head was obstructed. 3.1-19(b)		**2) How the facility identified other residents:** A facility walkthrough was completed and any closets storage not in compliance with Sprinkler System Was corrected immediately. This deficient practice has the potential to affect residents. **3) Measures put into place/ System changes:** Sprinkler obstruction storage will be added to Monthly PM Logs. Executive Director / Designees will randomly check rooms during rounds. Executive Director / Designee will round with Maintenance Supervisor x 2 monthly. Staff will be in serviced by 03/15/19. **4) How the corrective actions will be monitored:** . The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance 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.	

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			5) Date of compliance: 05/03/2019	
K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 1. Based on record review and interview, the facility failed to provide written documentation or other evidence the sprinkler system components had been inspected and tested for 2 of 4 quarters. LSC 4.6.12.1 requires any device, equipment or system required for compliance with this Code be maintained in accordance with applicable NFPA requirements. Sprinkler systems shall be properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 4.3.1 requires records shall be made for all inspections, tests, and maintenance of the system	K 0353	**K 353 Sprinkler System** **The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the*	05/03/2019

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	components and shall be made available to the authority having jurisdiction upon request. 4.3.2 requires that records shall indicate the procedure performed (e.g., inspection, test, or maintenance), the organization that performed the work, the results, and the date. NFPA 25, 5.2.5 requires that water flow alarm devices shall be inspected quarterly to verify they are free of physical damage. NFPA 25, 5.3.3.1 requires the mechanical water flow alarm devices including, but not limited to, water motor gongs, shall be tested quarterly. 5.3.3.2 requires vane-type and pressure switch-type water flow alarm devices shall be tested semiannually. This deficient practice could affect all residents, staff, and visitors in the facility. Findings include: Based on review of the quarterly sprinkler system inspection records with the Maintenance Director on 02/13/19 at 10:18 a.m., the last documented sprinkler inspection was dated 06-05-18. There was no quarterly sprinkler system inspection reports available for the third and fourth quarters of 2018. During an interview at the time of records review, the Maintenance Director acknowledged there was no written documentation available to show the sprinkler system had been inspected during the third and fourth quarters of 2018 and after a call to the sprinkler company, stated all documentation was faxed to the facility and the quarterly inspections were not part of the fax. 3.1-19(b) 2. Based on record review and interview, the facility failed to maintain 6 of 11 tamper switches on the automatic sprinkler system in accordance with NFPA 25. LSC 9.7.5 requires all sprinkler		*facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** Executive Director immediately contacted Koorsen's and Meeting with representative on 02/28/2019 to discuss 1. Sprinkler Inspection 2. Valve Tamper Switches 3. Fire Pump 4. Fire Hydrant 5. Sprinkler System Valves Inspected / Documented Monthly Fire Hydrant per Koorsen should not completed until May 3, 2019 due to weather and damage water freezing will due to hydrant. Letter on File from Kooren. Sprinkler Inspection being completed. Documentation obtained from Koorsen regarding sprinkler system. Hydrant will be inspected by 5/3/2019 **2) How the facility identified other residents:** All residents have the potential to be affected By this deficient practice. No negative outcome to	

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	systems shall be inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 2011 Edition, Section 4.1.4.1 states the property owner or designated representative shall correct or repair deficiencies or impairments that are found during the inspection, test and maintenance required by this standard. Corrections and repairs shall be performed by qualified maintenance personnel or a qualified contractor. NFPA 25, 4.3.1 requires records shall be made for all inspections, tests, and maintenance of the system components and shall be made available to the authority having jurisdiction upon request. This deficient practice could affect all residents, staff, and visitors in the facility. Findings include: Based on records review of Hydro Fire Protection's "Fire Sprinkler System Inspection" documentation dated 06/05/18 with Maintenance Director on 02/13/19 at 10:18 a.m., under the deficiencies section on page eight of the report; six valve tamper switches were listed as deficient and stated "there was no alarm signal received by the alarm panel whenever the valves were operated." Based on interview at the time of record review, the Maintenance Director acknowledged there was no written documentation available to show the sprinkler system had been repaired since the last inspection on 06/05/18 and after a call to the sprinkler company, stated all documentation was faxed to the facility and the no other inspections or repairs were a part of the fax. 3.1-19(b)		Staff, visitors and or residents. **3) Measures put into place/ System changes:** **Maintenance Director** Executive Director will oversee the PM Maintenance Logs Monthly to ensure compliance. Maintenance Director will be responsible for Compliance of scheduling services timely. **4) How the corrective actions will be monitored:** . The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance 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. **5) Date of compliance:** 05/03/2019	

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	3. Based on record review and interview, the facility failed to maintain 1 of 1 fire pumps on the automatic sprinkler system were in accordance with NFPA 25. LSC 9.7.5 requires all sprinkler systems shall be inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 2011 Edition, Section 8.3.1.2 electric motor-driven fire pumps shall be operated monthly. Table 8.1.1.2 states fire pumps systems shall be visually inspected weekly in accordance with 8.2.2. This deficient practice affects all occupants. Findings include: Based on record review with the Maintenance Director on 02/13/19 at 10:20 a.m., the facility was conducting operation of the fire pump weekly but the documentation showed there was no fire pump operation before the date of 11-08-18. Also, no weekly visual inspection according to the list in NFPA 25, 2011 Edition, Section 8.2.2 was recorded. Based on an interview at the time of record review, the Maintenance Director stated the documentation before 11-08-18 was completed by the previous Maintenance Director, did not know where the previous documentation was located, and was completing checks according to the facility's paperwork. 3.1-19(b) 4. Based on observation, observation, and interview, the facility failed to ensure 1 of 1 private fire hydrant was continuously maintained in reliable operating condition and inspected and tested periodically. NFPA 25, 2011 Edition, the Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection			

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	Systems, Table 7.1.1.2 requires wet and dry barrel hydrants to be inspected annually and after each operation. This deficient practice affects all occupants. Findings include: Based on observation with the Maintenance Director on 02/13/18 at 12:55 p.m., there was a fire hydrant outside the employee's entrance by the post indicator valve (PIV) and fire department connection. Based on records review with the Maintenance Director at 10:32 p.m., no documentation could be provided to show the facility's private fire hydrant was inspected annually. Based on an interview at the time of records review, the Maintenance Director confirmed the hydrant belongs to the facility and no documentation of an annual inspection was available for review. 3.1-19(b) 5. Based on record review and interview, the facility failed to maintain 1 of 1 sprinkler system in accordance with LSC 9.7.5. LSC 9.7.5 requires all automatic sprinkler systems shall be inspected and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 2011 edition, Table 5.1.1.2 indicates the required frequency of inspection and testing. NFPA 25, 5.2.4.1 states gauges on wet pipe sprinkler systems shall be inspected monthly and gauges on dry systems (5.2.4.2) shall be inspected weekly to ensure normal water or air pressure is being maintained. NFPA 25 13.3.2.1 states valves should be inspected weekly or valves secured locks or supervised (13.3.2.1.1) shall be permitted to be inspected monthly. This			

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	deficient practice could affect all occupants. Findings include: Based on records review with the Maintenance Director on 02/13/19 at 10:00 a.m., documentation was provided to show the wet sprinkler system gauges were inspected monthly but there was no documentation to show the sprinkler system valves were inspected monthly. Based on interview at the time of record review, the Maintenance Director agreed the control values were not inspected monthly. 3.1-19(b)			
K 0354 SS=C Bldg. 01	NFPA 101 Sprinkler System - Out of Service Sprinkler System - Out of Service Where the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined, recommendations are submitted to management or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where the sprinkler system is out of service for more than 10 hours in a 24-hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler system has been returned to service. 18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25) Based on record review and interview, the facility failed to provide 1 of 1 correct written policies in the event the automatic sprinkler system has to be placed out-of-service for 10 hours or more in a 24-hour period in accordance with LSC, Section 9.7.5. LSC 9.7.6 requires sprinkler impairment	K 0354	**K 354-** **The facility requests paper compliance for this citation.** *This Plan of Correction is the*	05/03/2019

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	procedures comply with NFPA 25, 2011 Edition, the Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 15.5.2 requires nine procedures that the impairment coordinator shall follow. A.15.5.2 (4) (b) states a fire watch should consist of trained personnel who continuously patrol the affected area. Ready access to fire extinguishers and the ability to promptly notify the fire department are important items to consider. During the patrol of the area, the person should not only be looking for fire, but making sure that the other fire protection features of the building such as egress routes and alarm systems are available and functioning properly. This deficient practice could affect all occupants in the facility. Findings include: Based on records review with the Maintenance Director and Assistant Director of Nursing on 02/13/19 at 10:52 a.m., the facility provided fire watch plan documentation but it was not for the Marion facility. There were two different fire watches provided; one from the previous owners and one from the current owners. The provided fire watch from the current owners was reviewed. All contact numbers, such as the fire department, was for the Peru facility and not the Marion facility. Also, the plan failed to include contacting the Indiana State Department of Health via the ISDH Gateway link at https://gateway.isdh.in.gov as the primary method or by the secondary method when the ISDH Gateway is nonoperational by completing the Incident Reporting form and e-mailing it to incidents@isdh.in.gov. The plan just stated "ISDH Gateway/e-mail" Based on interview during		*center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** The closets in rooms E129, E118, E137, and E130 had storage near/touching sprinkler were moved immediately. **2) How the facility identified other residents:** A facility walk through was completed and any closets storage not in compliance with Sprinkler System Was corrected immediately. This deficient practice has the potential to affect residents. **3) Measures put into place/ System changes:** Sprinkler obstruction storage will be added to Monthly PM Logs. Executive	

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	the record review, the Maintenance Director and Assistant Director of Nursing acknowledged the fire watch documentation provided was the current policy, contained the wrong phone numbers and only stated ISDH Gateway/e-mail, not the complete ISDH Gateway link or at the e-mail address listed above. 3.1-19(b)		Director / Designees will randomly check rooms during rounds. Executive Director / Designee will round with Maintenance Supervisor x 2 monthly. Staff will be in serviced **4) How the corrective actions will be monitored:** . The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance 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. **5) Date of compliance:** 05/03/2019	
K 0355 SS=B Bldg. 01	NFPA 101 Portable Fire Extinguishers Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 Based on observation and interview, the facility failed to inspect 2 of 2 portable fire extinguishers in the kitchen each month. NFPA 10, Standard for Portable Fire Extinguishers, Section 7.2.1.2 states fire extinguishers shall be inspected either	K 0355	**K 355 – Fire Extinguishers** **The facility requests paper compliance for this citation.**	05/03/2019

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	manually or by means of an electronic device / system at a minimum of 30-day intervals. Section 7.2.2 states periodic inspection or electronic monitoring of fire extinguishers shall include a check of at least the following items: (1) Location in designated place (2) No obstruction to access or visibility (3) Pressure gauge reading or indicator in the operable range or position (4) Fullness determined by weighing or hefting for self expelling-type extinguishers, cartridge-operated extinguishers, and pump tanks (5) Condition of tires, wheels, carriage, hose, and nozzle for wheeled extinguishers (6) Indicator for nonrechargeable extinguishers using pushto-test pressure indicators. Section 7.2.4.1 states personnel making manual inspections shall keep records of all fire extinguishers inspected, including those found to require corrective action. Section 7.2.4.3 requires where at least monthly manual inspections are conducted, the date the manual inspection was performed and the initials of the person performing the inspection shall be recorded. Section 7.2.4.4 requires where manual inspections are conducted, records for manual inspections shall be kept on a tag or label attached to the fire extinguisher, on an inspection checklist maintained on file, or by an electronic method. Section 7.2.4.5 requires records shall be kept to demonstrate that at least the last 12 monthly inspections have been performed. This deficient practice could affect staff in the kitchen. Findings include: Based on observation during a tour of the facility with the Maintenance Director on 02/13/19 at 3:10 p.m., the monthly inspection tag on the ABC and K-class fire extinguisher located in the kitchen		*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** The fire extinguishers were inspected immediately And found to be in Life Safety Compliance **2) How the facility identified other residents:** All residents have the potential to be affected by this deficient practice. No residents have been affected by this deficient practice and or Dietary Staff **3) Measures put into place/ System changes:** Extinguisher Inspections will be added to monthly PM Logs. Maintenance Director will be responsible	

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	lacked documentation of a monthly inspections for December of 2018. Based on interview at the time of observation, the Maintenance Director confirmed the two extinguishers located in the kitchen were missing the December visual inspection. 3.1-19(b)		For monthly checks. Oversight will be responsibility Of Executive Director. Monthly logs will be reviewed by Executive Director. **4) How the corrective actions will be monitored:** . The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance 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. **5) Date of compliance:** 05/03/2019	
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 apply to auxiliary spaces that do not contain flammable or combustible material.			

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	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 66 of 66 resident room corridor doors were 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 12 residents. Findings include: Based on observation with the Maintenance Director on 02/13/19 from 11:35 a.m. to 3:20 p.m., the corridor resident room doors to room E111 was propped open with a chair and doors to room E131, E138, D151, D134, D101 were propped open	K 0363	**K 363- Corridors/ Doors** **The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of*	05/03/2019

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	with trash cans. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned corridor door would not close unless the chair or trash cans were moved first. 3.1-19(b)		*correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** Chairs/trash cans were immediately removed from rooms E131, E138, D151, D134, and D101 using to prop open doors. 2) **How the facility identified other residents:** This practice has potential to affect all residents in facility. Rounds were conducted to ensure no other doors were propped open with objects. **3) Measures put into place/ System changes:** Staff will be re-in serviced on Life Safety Compliance of not using any equipment to prop doors open. Compliance will be monitored during daily rounds. Doors found to be in non-compliance will be immediately addressed. Staff will alert Maintenance Director if any door is non-functional	

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			using, Maintenance Work Order. Maintenance Director will assess doors and repair as necessary, including rooms E131, E138, D151, D134 and D101 using to prop open doors. **4) How the corrective actions will be monitored:** The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance 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. **5) Date of compliance: 05/03/2019**	
K 0372 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent			

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	to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. 1. Based on observation and interview, the facility failed to ensure the penetrations caused by the passage of wire and/or conduit through 1 of 5 smoke barrier walls were protected to maintain the smoke resistance of each smoke barrier. LSC Section 19.3.7.5 requires smoke barriers to be constructed in accordance with LSC Section 8.5 and shall have a minimum ½ hour fire resistive rating. LSC Section 8.5.2.1 requires smoke barriers to be continuous from an outside wall to an outside wall, from a floor to a floor, or from a smoke barrier to a smoke barrier, or by use of a combination thereof. 8.5.6.2 requires penetrations for cables, cable trays, conduits, pipes, tubes, vents, wires, and similar items to accommodate electrical, mechanical, plumbing, and communications systems that pass through a wall, floor, or floor/ceiling assembly constructed as a smoke barrier, or through the ceiling membrane of the roof/ceiling of a smoke barrier assembly, shall be protected by a system or material capable of restricting the movement of smoke. This deficient practice could affect staff and at least 30 residents in two smoke compartments. Findings include: Based on observations during a tour of the facility with the Maintenance Director on 02/13/19 at 3:20 p.m., above the drop ceiling of the E hall smoke wall there was an half inch gap around a wire. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned condition and provided the measurements of the unsealed penetration.	K 0372	**K 372- Subdivision of Building Spaces – Smoke Barrie** **The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** The ½ inch gap on E hall and the quarter inch unsealed gap by D hall has been repaired using Fire approved caulking. 2) **How the facility identified other residents:** This practice has potential to affect all residents in facility. **3) Measures put into place/ System changes:** Maintenance will round facility and	05/03/2019

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	3.1-19(b) 2. Based on observation and interview, the facility failed to ensure the penetrations caused by the passage of wire and/or conduit through 1 of 1 ceiling smoke barriers were protected to maintain the smoke resistance of each smoke barrier. LSC Section 19.3.7.5 requires smoke barriers to be constructed in accordance with LSC Section 8.5 and shall have a minimum ½ hour fire resistive rating. LSC Section 8.5.2.1 requires smoke barriers to be continuous from an outside wall to an outside wall, from a floor to a floor, or from a smoke barrier to a smoke barrier, or by use of a combination thereof. 8.5.6.2 requires penetrations for cables, cable trays, conduits, pipes, tubes, vents, wires, and similar items to accommodate electrical, mechanical, plumbing, and communications systems that pass through a wall, floor, or floor/ceiling assembly constructed as a smoke barrier, or through the ceiling membrane of the roof/ceiling of a smoke barrier assembly, shall be protected by a system or material capable of restricting the movement of smoke. This deficient practice could affect staff and at least 40 residents in two smoke compartment. Findings include: Based on observations during a tour of the facility with the Maintenance Director on 02/13/19 at between 1:40 p.m. and 3:30 p.m., in the ceiling by room E 137 and above the ceiling tiles by the D hall smoke wall there was a one and a half foot by three foot dry wall patch covering a hole. There was a quarter inch unsealed gap around the pieces of drywall. Based on interview at the time of observation, the Maintenance Director acknowledged each aforementioned condition and provided the measurements of the unsealed gap		any unsealed gaps will be repaired. Any non-compliance findings will be reported to Executive Director. **4) How the corrective actions will be monitored:** . The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance 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. **5) Date of compliance:** **05/03/2019**	

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	around the drywall patch. 3.1-19(b)			
K 0511 SS=D Bldg. 01	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 Based on observation, the facility failed to ensure 1 of 1 electrical junction boxes in the resident store room were maintained in a safe operating condition. LSC 19.5.1.1 requires utilities comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code. NFPA 70, 2011 Edition, Article 314.28(3) (c) states junction boxes shall be provided with covers compatible with the box and suitable for the conditions of use. Where used, metal covers shall comply with the grounding requirements of 250.110. This deficient practice could affect staff and in the basement. Findings include: Based on observation during a tour of the facility with the Maintenance Director on 02/13/19 at 3:20 p.m., in the basement resident's store room an electrical junction box on ceiling by the florescent light did not contain a cover and had exposed electrical wiring. Based on interview at the time of the observations, the Maintenance Director acknowledged the electrical junction box was not provided with a cover and had exposed wires.	K 0511	**K 511 – Utilities- Gas / Electric** **The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** The electrical junction located in resident's store room has been repaired along with electrical	05/03/2019

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	3.1-19(b)		wiring. **2) How the facility identified other residents:** All residents could be affected; facility has no negative outcome **3) Measures put into place/ System changes:** Maintenance Director will round facility And any non-compliance of wiring / covers on electrical boxes will be repaired. **4) How the corrective actions will be monitored:** . The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance 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. **5) Date of compliance, 05/03/2019**	
K 0521 SS=F Bldg. 01	NFPA 101 HVAC HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's			

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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
	specifications. 18.5.2.1, 19.5.2.1, 9.2 Based on record review, observation and interview; the facility failed to ensure 7 of 179 fire dampers in the facility were inspected and provided necessary maintenance at least every four years in accordance with NFPA 90A. LSC 9.2.1 requires heating, ventilating and air conditioning (HVAC) ductwork and related equipment shall be in accordance with NFPA 90A, Standard for the Installation of Air-Conditioning and Ventilating Systems. NFPA 90A, 2012 Edition, Section 5.4.8.1 states fire dampers shall be maintained in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. NFPA 80, 2010 Edition, Section 19.4.1 states each damper shall be tested and inspected 1 year after installation. Section 19.4.1.1 states the test and inspection frequency shall then be every 4 years except for hospitals where the frequency is every 6 years. If the damper is equipped with a fusible link, the link shall be removed for testing to ensure full closure and lock-in-place if so equipped. The damper shall not be blocked from closure in any way. All inspections and testing shall be documented, indicating the location of the fire damper, date of inspection, name of inspector and deficiencies discovered. The documentation shall have a space to indicate when and how the deficiencies were corrected. This deficient practice could affect all residents, staff and visitors. Findings include: Based on records review with the Maintenance Director on 02/13/19 at 10:52 a.m., the Fire Damper Inspection dated 03-06-17 indicated six fire dampers could not be accessed and one fire damper that was broke and needed replaced. No	K 0521	**K 521 - HVAC** **The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** Executive Director contacted Brandt's for inspect / repair as needed on dampers**. Service scheduled 03/07/2019** **2) How the facility identified other residents:** All residents have the potential to be affected by this deficient practice. No residents have been affected by this deficient practice.	05/03/2019

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	other documentation was provided to show the seven dampers were fixed or re-inspected. Based on interview at the time of records review and exit conference, the Maintenance Director confirmed there were dampers on the inspection that were broken or could not inspect, and stated no other documentation could be found. 3.1-19(b)		**3) Measures put into place/ System changes:** Responsibility of Maintenance Director to schedule inspections, with oversight of Executive Director. **4) How the corrective actions will be monitored:** . The results of these audit will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance 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. **5) Date of compliance: 05/03/2019**	
K 0711 SS=C Bldg. 01	NFPA 101 Evacuation and Relocation Plan Evacuation and Relocation Plan There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. Employees are periodically instructed and kept informed with their duties under the plan, and a copy of the plan is readily available with telephone operator or with security. The plan addresses the basic response required of staff per 18/19.7.2.1.2 and provides for all of the fire safety plan components per 18/19.2.2. 18.7.1.1 through 18.7.1.3, 18.7.2.1.2, 18.7.2.2, 18.7.2.3, 19.7.1.1 through 19.7.1.3,			

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	19.7.2.1.2, 19.7.2.2, 19.7.2.3 Based on record review, observation, and interview, the facility failed to provide 1 of 1 written emergency fire safety plan that incorporated all items listed in NFPA 101, Section 19.7.2.2. 1. Use of alarms. 2. Transmission of alarms to fire department. 3. Emergency phone call to fire department 4. Response to alarms. 5. Isolation of fire. 6. Evacuation of immediate area. 7. Evacuation of smoke compartment. 8. Preparation of floors and building for evacuation. 9. Extinguishment of fire. This deficient practice affects all residents, staff and visitors in the event of an emergency. Findings include: A) Based on record review with the Maintenance Director and Assistant Director of Nursing on 02/13/19 at 11:19 a.m., the facility's fire safety plan located in the Emergency Preparedness plan did not explain the type of fire extinguishers in the facility and what kind of fire each type of extinguisher is used for. There was a list of where each type of fire extinguisher was located but it was for the building in Peru IN. not for the Marion facility. Based on interview at the time of records review, the Maintenance Director and Assistant Director of Nursing looked through the plan and stated there was no other information on what type of fire extinguishers are in the facility. B) Based on record review with the Maintenance Director and Assistant Director of Nursing on 02/13/19 at 11:19 a.m., the facility provided information on evacuation of smoke	K 0711	**K 711 Evacuation and Location** **The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** Policies were reviewed and updated **2) How the facility identified other residents:** All residents have the potential to be affected By this deficient practice. No negative outcome to Staff, visitors and or residents. **3) Measures put into place/ System changes:** Staff will be in-serviced on policies and placed in Fire book . Executive is responsible for	05/03/2019

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	compartments but did not address the locations of smoke/fire barriers or identify doors that could be mistaken as a smoke barrier. Based on observation during a tour of the facility with the Maintenance Director between 12:00 p.m. to 3:00 p.m., there was one separation fire wall, two smoke wall, two stairwells separation barrier and one cross-corridor doors to the community room that was not a complete barrier and could be mistaken as smoke doors. Based on interview, the Maintenance Director and Assistant Director stated the facility map did not identify the smoke/fire barriers and no other documentation was available to show where all smoke/fire barriers were located. 3.1-19(b)		oversight. New staff will be oriented to policies During orientation. **4) How the corrective actions will be monitored:** . The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance 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. **5) Date of compliance:** 05/03/2019	
K 0712 SS=F Bldg. 01	NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7			

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	Based on record review and interview, the facility failed to conduct quarterly fire drills for 2 of 4 quarters. LSC 19.7.1.6 requires drills to be conducted quarterly on each shift under varied conditions. This deficient practice affects all staff and residents. Findings include: Based on records review with the Maintenance Director on 02/13/19 at 10:02 a.m., there was no documentation for a second shift fire drill in the second quarter of 2018. Additionally, there no was no documentation for a third shift fire drill in the third quarter of 2018. Based on interview at the time of record review, the Maintenance Director stated the drills were completed by the previous Maintenance Director and could not find documentation of the aforementioned drills. 3.1-19(b) 3.1-51(c)	K 0712	**K 712 – Fire Drills** **The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** Fire drills were conducted on Second and Third shift by the Maintenance Director. **2) How the facility identified other residents:** All residents, staff and visitors have the Potential to be affected by this deficient practice. Facility has not had any negative outcome. **3) Measures put into place/ System changes:** Maintenance PM logs will be updated to ensure	05/03/2019

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			Monthly Fire Drills are completed. Maintenance will be responsible to conduct monthly fire drills timely, this process will be monitored with oversight of Executive Director. **4) How the corrective actions will be monitored:** . The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance 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. **5) Date of compliance** **05/03/2019**	
K 0741 SS=F Bldg. 01	NFPA 101 Smoking Regulations Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking.			

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	(2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4			
	Based on observation, records review, and interview, the facility failed to ensure 1 of 1 smoking policies was written for the facility and ensure 1 of 8 exits did not contain cigarette butts on the ground. This deficient practice affects all residents. Findings include: Based on records review with the Maintenance Director on 02/13/19 at 11:33 a.m., the smoking policy titled "Aperion Care Smoking Safety" stated if the facility allowed smoking a designated smoking area would be designated, but the policy did not state if the facility does or does not allow smoking. Furthermore, based on observations with the Maintenance Director at 1:33 p.m., smoking on property was evident due to a cigarette butt on top of the snow outside the employee exit. Based on interview at the time of observation, the Maintenance Director stated the facility is a smoke free campus, confirmed there	K 0741	**K 741 Smoking Regulations** **The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken**	05/03/2019

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	was a cigarette butt right outside the employee exit, and stated the smoking policy does not state if the facility chose to allow or not allow smoking. 3.1-19(b)		**for those residents identified: Smoking policy reviewed and revised, added Aperion Marion is a non-smoking facility. Maintenance / Designee rounded facility grounds and cleaned up any cigarette butts found.** **2) How the facility identified other residents:** **All residents have the potential to be affected By this deficient practice. No negative outcome to Staff, visitors and or residents.** **3) Measures put into place/ System changes:** **Maintenance / Designee will round grounds 5x weekly and will be added to daily Maintenance PM logs. To check for cigarette butts. Findings will be reported To the Executive Director of non-compliance and where butts were area of concern. A sign will be posted at Entrance to remind visitors facility is non-smoking. Staff will be in-serviced on smoking policy.** **4) How the corrective actions will be monitored:** . The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or	

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			until 100% compliance 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. **5) Date of compliance 05/03/2019**	
K 0761 SS=F Bldg. 01	Based on observation, records review, and interview, the facility failed to ensure annual inspection and testing of 5 of 6 fire door assemblies were completed in accordance of LSC 19.1.1.4.1.1 communicating openings in dividing fire barriers required by 19.1.1.4.1 shall be permitted only in corridors and shall be protected by approved self-closing fire door assemblies. (See also Section 8.3.) LSC 8.3.3.1 Openings required to have a fire protection rating by Table 8.3.4.2 shall be protected by approved, listed, labeled fire door assemblies and fire window assemblies and their accompanying hardware, including all frames, closing devices, anchorage, and sills in accordance with the requirements of NFPA 80, Standard for Fire Doors and Other Opening Protectives, except as otherwise specified in this Code. NFPA 80 5.2.1 states fire door assemblies shall be inspected and tested not less than annually, and a written record of the inspection shall be signed and kept for inspection by the AHJ. NFPA 80, 5.2.4.1 states fire door assemblies shall be visually inspected from both sides to assess the overall condition of door	K 0761	**K 761 – Maintenance Inspection& Testing / Doors** **The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:**	05/03/2019

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	assembly. NFPA 80, 5.2.4.2 states as a minimum, the following items shall be verified: (1) No open holes or breaks exist in surfaces of either the door or frame. (2) Glazing, vision light frames, and glazing beads are intact and securely fastened in place, if so equipped. (3) The door, frame, hinges, hardware, and noncombustible threshold are secured, aligned, and in working order with no visible signs of damage. (4) No parts are missing or broken. (5) Door clearances do not exceed clearances listed in 4.8.4 and 6.3.1.7. (6) The self-closing device is operational; that is, the active door completely closes when operated from the full open position. (7) If a coordinator is installed, the inactive leaf closes before the active leaf. (8) Latching hardware operates and secures the door when it is in the closed position. (9) Auxiliary hardware items that interfere or prohibit operation are not installed on the door or frame. (10) No field modifications to the door assembly have been performed that void the label. (11) Gasketing and edge seals, where required, are inspected to verify their presence and integrity. This deficient practice could affect all residents. Findings include: Based on records review with the Maintenance Director on 02/13/19 at 10:02 a.m., there was only an annual fire door inspection for the occupancy separation fire door and no inspection for the four stairwell fire doors and the oxygen trans-fill room fire door. Based on observation during the tour between 11:50 a.m. and 3:00 p.m., there were a four fire doors at the top and bottom of the two		Four stair well and the oxygen trans-fill room fire doors was inspected by Maintenance. **2) How the facility identified other residents:** All residents could be affected; facility has no negative outcome **3) Measures put into place/ System changes:** Maintenance Director will round facility and ensure Fire doors are recorded on log / map of facility. Maintenance was in-serviced on the inspection and testing of fire doors. **4) How the corrective actions will be monitored:** Monitoring of inspection and testing of fire doors will be a joint effort of Maintenance and Executive Director. Monthly monitoring. Any concerns will be addressed in QAA monthly x6 months or until 100 % compliance is achieved for 3 consecutive months. **5) Date of compliance:** 05/03/2019	

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	stairwells, and one fire door to the oxygen trans-fill room. Based on interview at the time of records review and observation, the Maintenance Director stated the aforementioned doors were fire doors and no inspection has been performed. 3.1-19(b)			
K 0914 SS=F Bldg. 01	NFPA 101 Electrical Systems - Maintenance and Testing Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) Based on observation, record review and interview, the facility failed to ensure non-hospital grade electrical receptacles at 66 of 66 resident care locations were tested at least annually.	K 0914	**K 914 – Electrical Systems Maintenance and Testing** **The facility requests paper**	05/03/2019

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	NFPA 99, Health Care Facilities Code 2012 Edition, Section 6.3.4.1.3 states receptacles not listed as hospital-grade, at patient bed locations and in locations where deep sedation or general anesthesia is administered, shall be tested at intervals not exceeding 12 months. Additionally, Section 6.3.3.2, Receptacle Testing in Patient Care Rooms requires the physical integrity of each receptacle shall be confirmed by visual inspection. The continuity of the grounding circuit in each electrical receptacle shall be verified. Correct polarity of the hot and neutral connections in each electrical receptacle shall be confirmed; and retention force of the grounding blade of each electrical receptacle (except locking-type receptacles) shall be not less than 115 grams (4 ounces). This deficient practice could affect all residents. Findings include: Based on observations with the Maintenance Director during a tour of the facility on 02/13/19 from 11:00 a.m. to 3:15 p.m., the facility's 66 resident care rooms/locations contained four to eight electrical receptacles in each care area. Based on records review at 11:30 a.m. no documentation was available to show electrical receptacles in resident care areas were tested annually. Based on interview at the time of the observation, the Maintenance Director indicated all of the electrical receptacles in the resident care areas were not hospital-grade and also indicated there was no documentation of annual testing per NFPA 99, Receptacle Testing requirements. 3.1-19(b)		**compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** Maintenance purchased electrical tester and tested 66 receptacles. **2) How the facility identified other residents** All residents have the potential to be affected By this deficient practice. No negative outcome to Staff, visitors and or residents. **3) Measures put into place/ System changes:** Maintenance Director will select 3 rooms / monthly and check receptacles Executive Director will oversee the PM Maintenance Logs Monthly to ensure compliance.	

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			Maintenance Director will be responsible for Compliance of scheduling services timely. **4) How the corrective actions will be monitored:** . The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance 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. **5) Date of compliance:** 05/03/2019	
K 0918 SS=F Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a			

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APERION CARE MARION LLC	614 WEST 14TH STREET MARION, IN 46953

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	year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)			
	1. Based on record review and interview, the facility failed to maintain a complete written record of monthly generator load testing for 7 of the last 12 months. Chapter 6.4.4.1.1.4(a) of 2012 NFPA 99 requires monthly testing of the generator serving the emergency electrical system to be in accordance with NFPA 110, the Standard for Emergency and Standby Powers Systems, Chapter 8. NFPA 110 8.4.2 requires diesel generator sets in service to be exercised at least once monthly, for a minimum of 30 minutes. Chapter 6.4.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all occupants.	K 0918	**K 918 - Electrical Systems** **The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is*	05/03/2019

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	Findings include: Based on records review with the Maintenance Director on 02/13/19 at 10:47 a.m., prior to 09-27-18 no documentation was available for review to show the diesel generator set in service was exercised at least once monthly, for a minimum of 30 minutes. Based on an interview at the time of record review, the Maintenance Director stated the monthly generator tests before 09-27-18 were conducted by the prior Maintenance Director and did not know where the documentation was located. 3.1-19(b) 2. Based on record review and interview, the facility failed to ensure a written record of weekly inspections for the generator was maintained for 28 of 52 weeks. NFPA 99, 6.4.4.1.3 requires onsite generators shall be maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. NFPA 110, 8.4.1 requires an Emergency Power Supply System (EPSS) including all appurtenant components, shall be inspected weekly and exercised monthly. NFPA 99, 6.4.4.2 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors. Findings include: Based on records review with the Maintenance Director on 02/13/19 at 10:47 a.m., prior to 09-25-18 no documentation was available for review to show the diesel generator sets in service was inspected weekly. Based on an interview at the		*required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** The generator test for 30 mins was conducted and components were inspected by Maintenance. Facility signed an agreement with Evapar. Scheduled Maintenance / lights are scheduled 3/10/2019. **2) How the facility identified other residents:** All residents have the potential to be affected By this deficient practice. No negative outcome to Staff, visitors and or residents. **3) Measures put into place/ System changes:** Testing will be put on weekly / monthly PM Maintenance Logs. Maintenance is responsible with over sight of Executive Director. **4) How the corrective actions will be monitored:** . The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved	

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	time of record review, the Maintenance Director stated the weekly generator inspections before 09-25-18 were conducted by the prior Maintenance Director and did not know where the documentation was located. 3.1-19(b) 3. Based on record review and interview, the facility failed to exercise 1 of 1 generators annually to meet the requirements of NFPA 110, 2010 Edition, the Standard for Emergency and Standby Powers Systems, Chapter 8.4.2. Section 8.4.2 states diesel generator sets in service shall be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods: (1) Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer (2) Under operating temperature conditions and at not less than 30 percent of the EPS (Emergency Power Supply) nameplate kW rating. Section 8.4.2.3 states diesel-powered EPS installations that do not meet the requirements of 8.4.2 shall be exercised monthly with the available EPSS (Emergency Power Supply System) load and shall be exercised annually with supplemental loads (Load Bank Test) at not less than 50 percent of the EPS nameplate kW rating for 30 continuous minutes and at not less than 75 percent of the EPS nameplate kW rating for 1 continuous hour for a total test duration of not less than 1.5 continuous hours. This deficient practice could affect all occupants. Findings include: Based on records review with the Maintenance Director on 02/13/19 at 10:47 a.m., the available monthly load testes did not record the load		x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **5) Date of compliance:** 05/03/2019	

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	percentage for the diesel powered generator. Also, the available load bank test for review had a date 11-29-16. Based on interview at the time of record review, the Maintenance Director stated the generator ran under load monthly but did not know if the load achieved 30 % of the generator's name plate rating. Additionally, the Maintenance Director acknowledged a load bank test for the generator had not occurred within the past year. 3.1-19(b) 4 Based on observation and interview, the facility failed to ensure 2 of 2 emergency task generator battery backup lights were maintained. NFPA 110, 2010 Edition at section 7.3.1 requires the Level 1 or Level 2 EPS equipment location(s) shall be provided with battery-powered emergency lighting. This requirement shall not apply to units located outdoors in enclosures that do not include walk-in access. Section 7.9.3.1.1 (1) requires functional testing shall be conducted monthly, with a minimum of 3 weeks and a maximum of 5 weeks between tests, for not less than 30 seconds, (3) Functional testing shall be conducted annually for a minimum of 1 1/2 hours if the emergency lighting system is battery powered and (5) Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect all residents in the facility. Findings include: Based on records review with the Maintenance Director on 02/13/19 at 10:47 a.m., prior to 09-26-18 no documentation was available for review to show the emergency battery powered light at the generator and at the transfer switch was tested			

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	monthly for a minimum of 30 seconds. Based on an interview at the time of record review, the Maintenance Director stated the monthly battery powered light tests before 09-27-18 were conducted by the prior Maintenance Director and did not know where the documentation was located. 3.1-19(b)			
K 0923 SS=E Bldg. 01	NFPA 101 Gas Equipment - Cylinder and Container Storag Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage			

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	room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99)			
	Based on observation and interview, the facility failed to ensure 1 of 2 cylinders of nonflammable gases such as oxygen were properly secured from falling. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 11.3.2 states storage for nonflammable gases greater than 8.5 cubic meters (300 cubic feet) but less than 85 cubic meters (3000 cubic feet) shall comply with 11.3.2.1 through 11.3.2.3. NFPA 99, Section 11.3.2.6 states cylinder or container restraints shall comply with 11.6.2.3. Section 11.6.2.3(11) states freestanding cylinders shall be properly chained or supported in a proper cylinder stand or cart. This deficient practice could affect 10 staff and visitors in the vicinity of the oxygen storage and trans-filling room. Findings include: Based on observations during a tour of the facility with the Maintenance Director on 02/13/19 at 2:04 p.m., one of two 'E' type oxygen cylinders were standing upright on the floor of the oxygen storage and trans-filling room and was not properly chained or supported in a proper cylinder stand or cart. Based on interview at the time of	K 0923	**K 923 Storage of Cylinders** **The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** Facility contacted oxygen company and cylinder was picked	05/03/2019

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	observation, the Maintenance Director acknowledged one of two 'E' type oxygen cylinders in the aforementioned oxygen storage and trans-filling room was not properly chained or supported in a proper cylinder stand or cart. 3.1-19(b)		up **2) How the facility identified other residents:** All residents could be affected, facility had no negative outcome **3) Measures put into place/ System changes:** Oxygen tanks if needed in facility will be secured per regulations. Oversight will be responsibility of Director of Nursing / Executive Director. **4) How the corrective actions will be monitored:** . The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance 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. **5) Date of compliance:** 05/03/2019	
K 0927 SS=E Bldg. 01	NFPA 101 Gas Equipment - Transfilling Cylinders Gas Equipment - Transfilling Cylinders Transfilling of oxygen from one cylinder to			

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	another is in accordance with CGA P-2.5, Transfilling of High Pressure Gaseous Oxygen Used for Respiration. Transfilling of any gas from one cylinder to another is prohibited in patient care rooms. Transfilling to liquid oxygen containers or to portable containers over 50 psi comply with conditions under 11.5.2.3.1 (NFPA 99). Transfilling to liquid oxygen containers or to portable containers under 50 psi comply with conditions under 11.5.2.3.2 (NFPA 99). 11.5.2.2 (NFPA 99) Based on observation and interview, the facility failed to ensure 1 of 1 oxygen trans-filling rooms were separated from other areas in the facility in a room that is protected with a one hour fire-resistive construction in accordance with 2012 NFPA 99 11.5.2.3.1(1). This deficient practice could affect 20 residents in one smoke compartment. Findings include: Based on observations during a tour of the facility with the Maintenance Director on 02/13/19 at 2:04 p.m., the oxygen trans-filling room had a one inch hole in the wall by the door. Based on an interview at the time of observation, the Maintenance Director agreed there was an unsealed hole in the wall of the oxygen trans-filling room. 3.1-19(b)	K 0927	**K 927- Gas Equipment-Transfilling Cylinders** **The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** The one-inch hole in oxygen filling room has been repaired **2) How the facility identified**	05/03/2019

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			other residents: All residents have the potential to be affected By this deficient practice. No negative outcome to Staff, visitors and or residents. **3) Measures put into place/ System changes:** Maintenance will round facility and any areas of concerns will be addressed. Findings of rounds will be reported to the Executive Director. **4) How the corrective actions will be monitored:** . The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance 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. **5) Date of compliance:** 05/03/2019	