

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155580	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____	X3) DATE SURVEY COMPLETED  05/04/2016
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NAME OF PROVIDER OR SUPPLIER  APERION CARE TOLLESTON PARK	STREET ADDRESS, CITY, STATE, ZIP CODE 2350 TAFT ST GARY, IN 46404
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K 0000  Bldg. 01	<p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 05/04/16</p> <p>Facility Number: 008505 Provider Number: 155580 AIM Number: 200064830</p> <p>At this Life Safety Code survey, Aperion Care Tolleston Park was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>This one story facility with a partial basement was determined to be of Type V (111) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors. Battery powered smoke detectors are located in the North and South wing resident rooms; the PCU resident rooms</p>	K 0000		

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

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 0018 SS=E Bldg. 01	<p>are equipped with hard wired smoke detectors. The facility has the capacity for 180 and had a census of 101 at the time of this survey.</p> <p>All areas where the residents have customary access were sprinklered. A detached wood equipment storage shed was unsprinklered.</p> <p>Quality Review completed on 05/06/16 - DA</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Clearance between bottom of door and floor covering is not exceeding 1 inch. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Doors shall be provided with a means suitable for keeping the door closed. 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 8.2.3.2.1. Roller latches are prohibited by CMS regulations in all health care facilities. 19.3.6.3 Based on observation and interview, the facility failed to ensure 1 of 1 DON</p>	K 0018	<b>K018 NFPA 101 LIFE SAFETY CODE STANDARD The</b>	05/31/2016

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	<p>office, 1 of 1 Business office, and 1 of 1 Activities corridor doors had no impediments to closing. This deficient practice could affect staff and up to 13 residents.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director on 05/04/16 between 11:43 a.m. and 1:54 p.m., the following was discovered:</p> <p>a) a plastic door stop in the Director of Nursing office</p> <p>b) a wooden door stop in the Business office</p> <p>c) two separate plastic door stops in Activities</p> <p>Based on interview at the time of each observation, the Maintenance Director acknowledged each aforementioned condition.</p> <p>3.1-19(b)</p>		<p><b>facility requests paper compliance for this citation.</b></p> <p><i>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.</i></p> <p><i>The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p><b>1) Immediate actions taken for those residents identified:</b></p> <p>All door stops were removed. There were no residents cited in regard to this regulation.</p> <p><b>2) How the facility identified other residents:</b></p> <p>Staff and residents that reside at the community have the potential to be affected by the alleged deficient practice.</p> <p><b>3) Measures put into place/ System changes:</b></p> <p>Department heads make daily rounds in the facility to monitor environmental safety issues. Employees will be re-educated on the use of door stops by the Maintenance Director/designee by 6/03/16.</p> <p><b>4) How the corrective actions will be monitored:</b></p> <p>An Environmental QAPI tool will be utilized weekly x 4 and monthly thereafter, to monitor compliance with door stops. The results of these audits will be reviewed in</p>		

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K 0021 SS=E Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Doors in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure are self-closing and kept in the closed position, unless held open by as release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of:</p> <p>(a) The required manual fire alarm system and (b) Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system and (c) The automatic sprinkler system, if installed 18.2.2.2.6, 18.3.1.2, 19.2.2.2.6, 19.3.1.2, 7.2.1.8.2</p> <p>Door assemblies in vertical openings are of an approved type with appropriate fire protection rating. 8.2.3.2.3.1</p> <p>Boiler rooms, heater rooms, and mechanical equipment rooms doors are kept closed. Based on observation and interview, the facility failed to ensure 1 of 1 Kitchen doors serving hazardous areas was held open only by a device arranged to automatically close the door or close the door upon activation of the fire alarm system. This deficient practice could affect staff and up to 50 residents.</p> <p>Findings include:</p>	K 0021	<p>Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months.</p> <p><b>K021 NFPA 101 LIFE SAFETY CODE STANDARD 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</b></p>	05/31/2016			

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K 0025 SS=E Bldg. 01	Based on observations with the Maintenance Director on 05/04/16 at 12:45 p.m., the kitchen rolling fire door was held open by a device attached to the wall. Six trays stacked on top of one another was directly underneath the rolling fire door. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned condition.  3.1-19(b)  NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers shall be constructed to provide at least a one half hour fire resistance rating and constructed in		<i>the statement of deficiencies.</i> <i>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:</i> The tray covers were removed from under the rolling fire door in the kitchen. <b>2) How the facility identified other residents:</b> · Staff and residents that reside at the community have the potential to be affected by the alleged deficient practice. <b>3) Measures put into place/ System changes:</b> · The Dietary Manager will educate staff on the importance of keeping the rolling door area clear at all times by 6/03/16. <b>4) How the corrective actions will be monitored:</b> · The Dietary Manager will monitor during meal service for compliance. An Environmental QAPI tool will be utilized weekly x 4 and monthly thereafter, to monitor compliance with window obstruction. · 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.		

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	<p>accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels and steel frames.</p> <p>8.3, 19.3.7.3, 19.3.7.5</p> <p>Based on observation and interview, the facility failed to ensure 3 of 10 smoke barrier walls were maintained to provide a one hour fire resistance rating. LSC 8.3.2 requires smoke barriers shall be continuous from an outside wall to an outside wall. This deficient practice could affect staff and up to 50 residents.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director on 05/04/16 from 2:01 p.m. to 2:22 p.m., the following smoke barrier wall penetration were discovered:</p> <p>a) a four foot by two foot piece of drywall fell off in the attic smoke barrier near resident room 110</p> <p>b) a three quarter inch unsealed penetration inside conduit in the smoke barrier near resident room 122 above the drop ceiling.</p> <p>c) a seven eighths inch by two feet vertical gap between drywall in the attic smoke barrier near resident room 122</p> <p>d) c) two separate one inch unsealed in the Dining room smoke barrier.</p> <p>Additionally, there was a half inch</p>	K 0025	<p><b>K025 NFPA 101 LIFE SAFETY CODE STANDARD The facility requests paper compliance for this citation.</b></p> <p><i>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.</i></p> <p><i>The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p><b>1) Immediate actions taken for those residents identified:</b></p> <p>The attic drywall has been repaired. · The unsealed penetration has been repaired and drywall has been repaired near Room 122. · The dining room penetration has been repaired. · The ceiling tile has been replaced in the PCU Clean Linen Room. · The gap in the conduit in the PCU Electrical Room has been repaired. · The drywall will be installed near Room 330. · The drywall will be installed near Room 308.</p> <p><b>2) How the facility identified other residents:</b> · All Residents, staff and visitors have the potential to</p>	05/31/2016

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K 0045 SS=F Bldg. 01	<p>unsealed penetration. Based on interview at the time of each observation, the Maintenance Director acknowledged and provided the measurements for each unsealed penetration.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture will not leave the area in darkness. Lighting system shall be either continuously in operation or capable of automatic operation without manual intervention. 18.2.8, 19.2.8, 7.8 Based on observation and interview, the facility failed to provide exterior emergency lighting for 8 of 8 exit discharge exits. LSC Section 7.9.1.1 requires emergency lighting for means of egress shall be provided for the exit access and exit discharge. This deficient practice could affect all occupants.</p>	K 0045	<p>be affected by the alleged deficient practice. <b>3) Measures put into place/ System changes:</b> · Outside contractors will be educated, prior to completing services on the building, about proper fire wall penetrations. The Maintenance Director/designee will inspect for penetrations prior to job completion. <b>4) How the corrective actions will be monitored:</b> · An Environmental QAPI tool will be utilized monthly to monitor compliance with proper smoke barrier walls. · 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.</p> <p><b>K045 NFPA 101 LIFE SAFETY CODE STANDARD 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</b></p>	05/31/2016

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K 0046 SS=C Bldg. 01	<p>Findings include:</p> <p>Based on observation with the Maintenance Director on 05/04/16 between 11:37 a.m. and 3:12 p.m., all eight exit discharges had light bulbs. Based on interview at the time of each observation, the Maintenance Director did not think that the exterior light bulbs were on the generator.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1 1/2 hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1. Based on record review and interview;</p>	K 0046	<p><i>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:</i> There were no residents cited in regard to this regulation. <b>2) How the facility identified other residents:</b> All Residents, staff and visitors have the potential to be affected by the alleged deficient practice. <b>3) Measures put into place/ System changes:</b> The exterior lighting was connected to the generator at the time of the survey. The exterior lighting is now clearly marked on the emergency generator panel. <b>4) How the corrective actions will be monitored:</b> Emergency lighting is visually checked monthly and documented in the Preventative Maintenance Manual. The Executive Director will review the Preventative Maintenance Manual monthly. Findings will be presented to the Safety Committee for review.</p> <p><b>K046 NFPA 101 LIFE SAFETY CODE STANDARD The</b></p>	05/31/2016			

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	<p>the facility failed to ensure 2 of 2 Generator battery operated emergency lights in the facility was maintained in accordance with LSC 7.9. LSC 7.9.3, Periodic Testing of Emergency Lighting Equipment, requires a functional test to be conducted for 30 seconds at 30 day intervals and an annual test to be conducted on every required battery powered emergency lighting system for not less than a 1 ½ hour duration. Equipment shall be fully operational for the duration of the test. 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 occupants.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director on 05/04/16 at 11:24 a.m., the battery operated emergency light documentation contained only a checkmark. Based on interview at the time of observation, the Maintenance Director confirmed that the emergency lights are only tested for a second. Additionally, the Maintenance Director confirmed that no ninety minute test was performed.</p> <p>3.1-19(b)</p>		<p><b>facility requests paper compliance for this citation.</b> <i>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)</i></p> <p><b>Immediate actions taken for those residents identified:</b></p> <p>There were no residents cited in regard to this regulation. 2)</p> <p><b>How the facility identified other residents:</b> · All Residents, staff and visitors have the potential to be affected by the alleged deficient practice. 3)</p> <p><b>Measures put into place/ System changes:</b> · The battery operated emergency lighting has been replaced with lighting that meets the regulation. · The length of the battery operated emergency lighting test is will be documented on the Generator Log and Preventative Maintenance Manual monthly. · The Maintenance Director is responsible for compliance. 4)</p> <p><b>How the corrective actions will be monitored:</b> · Battery operated emergency lighting is checked monthly and documented in the Preventative</p>	

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K 0050 SS=F Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at 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. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM a coded announcement may be used instead of audible alarms. 18.7.1.2, 19.7.1.2</p> <p>Based on record review and interview, the facility failed to conduct fire drills quarterly on each shift for 2 of the last 4 calendar quarters. This deficient practice could affect all staff and residents.</p> <p>Findings include: Based on record review with the Maintenance Director on 05/04/16 at 10:44 a.m., the documentation for a second shift fire drill for the second and four quarter of 2015 was not available for review. Based on interview at the time of record review, the Maintenance Director</p>	K 0050	<p>Maintenance Manual. The Executive Director will review the Preventative Maintenance Manual monthly. Findings will be presented to the Safety Committee for review.</p> <p><b>K050 NFPA 101 LIFE SAFETY CODE STANDARD 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:</b></p>	05/31/2016	

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K 0056 SS=D Bldg. 01	acknowledged the lack of documentation. 3.1-19(b)  NFPA 101 LIFE SAFETY CODE STANDARD Where required by section 19.1.6, Health care facilities shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with section 9.7. Required sprinkler systems are equipped with water flow and tamper switches which are electrically interconnected to the building fire alarm. In Type I and II construction, alternative protection measures shall be permitted to be substituted for sprinkler protection in specific areas where State or local regulations prohibit sprinklers. 19.3.5, 19.3.5.1, NPFA 13 Based on observation and interview, the	K 0056	There were no residents cited in regard to this regulation. <b>2) How the facility identified other residents:</b> · All Residents, staff and visitors have the potential to be affected by the alleged deficient practice. <b>3) Measures put into place/ System changes:</b> · Fire drills will be completed quarterly on each shift and documented on the Fire Frill Evaluation Worksheet. · The Maintenance Director is responsible for compliance. <b>4) How the corrective actions will be monitored:</b> · Fire Drills are recorded in the Preventative Maintenance Manual. The Executive Director will review the Preventative Maintenance Manual monthly. Findings will be presented to the Safety Committee for review.	05/31/2016	
			<b>K056 NFPA 101 LIFE SAFETY</b>		

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	<p>facility failed to ensure the spray pattern for 2 of 2 sprinklers in the Staff Break Room was unobstructed. NFPA 25, 1998 Edition Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, Section 2-2.1.2 states unacceptable obstructions to spray patterns shall be corrected. NFPA 13, 1999 Edition Standard for the Installation of Sprinkler Systems, Table 5-6.5.1.2 states that distance between a sprinkler head an obstruction less than 1 foot away cannot be lower than the sprinkler head deflector. This deficient practice could affect staff only.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director on 05/04/16 at 11:53 a.m., the spray pattern for two sprinkler heads in the Staff Break Room was located next to ceiling box lights. Measurements showed the sprinkler head was four inches away from the ceiling lights. The ceiling lights were measured to be three inches lower than the sprinkler head deflector. Based on interview at the time of observation, the Maintenance Director acknowledged the abovementioned condition and provided the measurements.</p>		<p><b>CODE STANDARD</b> The facility requests paper compliance for this citation. <i>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.</i> 1)  <b>Immediate actions taken for those residents identified:</b> · There were no residents cited in regard to this regulation. 2)  <b>How the facility identified other residents:</b> · All Residents, staff and visitors have the potential to be affected by the alleged deficient practice. 3)  <b>Measures put into place/ System changes:</b> · The box lights located in the staff break room next to the sprinkler have been removed. · Outside contractors will be educated, prior to completing services on the building, about fire prevention regulations. The Maintenance Director/designee will inspect prior to job completion. 4)  <b>How the corrective actions will be monitored:</b> Overhead lighting is checked monthly and documented in the Preventative Maintenance Manual. The</p>				

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K 0062 SS=D Bldg. 01	<p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 sprinkler heads in the Beauty Shop was maintained. This deficient practice could affect staff and up to 2 residents.</p> <p>Findings include:</p> <p>Based on observations the Maintenance Director on 05/04/16 at 12:35 p.m., the Beauty Shop was missing an escutcheon ring. Based on interview at the time of observation, the Maintenance Director acknowledged the missing escutcheon.</p> <p>3.1-19(b)</p>	K 0062	<p>Executive Director will review the Preventative Maintenance Manual monthly. Findings will be presented to the Safety Committee for review</p> <p><b>K062 NFPA 101 LIFE SAFETY CODE STANDARD 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:</b> · There were no residents cited in regard to this regulation. <b>2) How the facility identified other residents:</b> · All Residents, staff and visitors have the potential to be affected by the alleged deficient practice. <b>3) Measures put into place/ System changes:</b> · The escutcheon ring in the Beauty</p>	05/31/2016	

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K 0070 SS=E Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Portable space heating devices shall be prohibited in all health care occupancies. Except it shall be permitted to be used in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212 degrees F (100 degrees C). 18.7.8, 19.7.8</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 policy prohibiting space heaters was maintained. This deficient practice could affect staff and up to 50 residents.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director on 05/04/16 at 11:49 a.m., a space heater was discovered</p>	K 0070	<p>Shop was replaced. Outside contractors will be educated, prior to completing services on the building, about proper regulations. The Maintenance Director/designee will inspect their work prior to job completion.</p> <p><b>4) How the corrective actions will be monitored:</b></p> <p>The sprinkler heads are checked quarterly and documented in the Preventative Maintenance Manual. The Executive Director will review the Preventative Maintenance Manual monthly. Findings will be presented to the Safety Committee for review</p> <p><b>K070 NFPA 101 LIFE SAFETY CODE STANDARD 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</b></p>	05/31/2016	

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K 0076 SS=D Bldg. 01	<p>in the Receptionist area which is open to the main entrance and dining room. Based on interview at the time of record review, the Maintenance Director acknowledged the aforementioned condition and confirmed the facility has a policy not allowing space heaters at all.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas shall be protected in accordance with NFPA 99, Standard for Health Care Facilities.</p> <p>(a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater</p>		<p><i>and/or executed solely because it is required by the provisions of federal and state law. 1) Immediate actions taken for those residents identified:</i></p> <p>There were no residents cited in regard to this regulation. 2) <b>How the facility identified other residents:</b> · All residents, staff and visitors have the potential to be affected by the alleged deficient practice. 3) <b>Measures put into place/ System changes:</b> · The space heater has been removed from the community. · Staff will be educated on the use of space heaters by the Maintenance Director/designee by 6/3/16. 4) <b>How the corrective actions will be monitored:</b> · An Environmental QAPI tool will be utilized monthly to monitor compliance with proper smoke barrier walls. · 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.</p>		

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	<p>than 3,000 cu.ft. are vented to the outside. 4-3.1.1.2 (NFPA 99), 8-3.1.11.1 (NFPA 99), 18.3.2.4, 19.3.2.4</p> <p>Based on observation and interview, the facility failed to ensure 6 of 8 cylinders in the South Shower room oxygen transfill room containing nonflammable gases such as oxygen were properly chained or supported in a proper cylinder stand or cart. NFPA 99, Health Care Facilities, 8-3.1.11.2(h) requires cylinder or container restraint shall meet NFPA 99, 4-3.5.2.1(b)27 which requires freestanding cylinders be properly chained or supported in a proper cylinder stand or cart. This deficient practice could affect staff only.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director on 05/04/16 at 1:39 p.m., the South Shower room oxygen transfil room contained six oxygen cylinders that were freestanding on the floor. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p>	K 0076	<p><b>K076 NFPA 101 LIFE SAFETY CODE STANDARD</b> The facility requests paper compliance for this citation. <i>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.</i> <b>1) Immediate actions taken for those residents identified:</b> · There were no residents cited in regard to this regulation. <b>2) How the facility identified other residents:</b> · All residents, staff and visitors have the potential to be affected by the alleged deficient practice. <b>3) Measures put into place/ System changes:</b> · The freestanding oxygen cylinders have been removed from the community. · Nursing staff will be educated on storage of oxygen cylinders by the Maintenance Director/designee by 6/3/16. <b>4) How the corrective actions will be monitored:</b> · An Environmental QAPI tool will be utilized monthly to monitor</p>	05/31/2016	

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K 0144 SS=C Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Generators inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110. 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110) Based on record review and interview, the facility failed to ensure 1 of 1 emergency generators was allowed a 5 minute cool down period after a load test. LSC 19.2.9.1 refers to LSC 7.9 which refers to LSC 7.9.2.3 which requires generators to be installed, tested and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, 1999 Edition. NFPA 110, 4-2.4.8 Time Delay on Engine Shutdown requires that a minimum time delay of 5 minutes shall be provided for unloaded running of the Emergency Power Supply (EPS) prior to shut down. This delay provides additional engine cool down. This time delay shall not be required on small (15 kW or less) air-cooled prime movers. This deficient practice could affect all residents, as well as staff and visitors in the facility.</p>	K 0144	<p>compliance with proper smoke barrier walls. 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.</p> <p><b>K144 NFPA 101 LIFE SAFETY CODE STANDARD 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:</b> There were no residents cited in regard to this regulation. <b>2) How the facility identified other residents:</b> All residents, staff and visitors have the potential to be affected by the alleged deficient practice. <b>3) Measures</b></p>	05/31/2016

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K 0147 SS=E Bldg. 01	<p>Findings include:</p> <p>Based on review of the facility's Emergency Generator monthly testing log with the Maintenance Director on 05/04/16 at 11:32 a.m., the generator log form documented the generator was tested monthly for at least 30 minutes under load, however, there was no documentation on the form that showed the generator had a cool down time following its load test. Based on interview at the time of record review, the Maintenance Director acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment shall be in accordance with National Electrical Code. 9-1.2 (NFPA 99) 18.9.1, 19.9.1</p> <p>1. Based on observation and interview, the facility failed to ensure 2 of 2 flexible cords were not used as a substitute for fixed wiring to provide power equipment with a high current draw. NFPA 70, National Electrical Code, 1999 Edition, Article 400-8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for</p>	K 0147	<p><b>put into place/ System changes:</b> · The Generator Testing Log has been updated to include the generator cool down time following a load test. The Maintenance Director will document all required information on the Generator Testing Log monthly. <b>4) How the corrective actions will be monitored:</b> · The Executive Director will review the Generator Testing Log monthly. Findings will be presented to the Safety Committee for review.</p> <p><b>K147 NFPA 101 LIFE SAFETY CODE STANDARD 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</b></p>	05/31/2016			

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	<p>fixed wiring of a structure. This deficient practice affects staff only.</p> <p>Findings include:</p> <p>Based on observation with Maintenance Director on 05/04/16 at 11:43 a.m. then again at 12:38 p.m., a surge protector was powering a microwave, refrigerator, and coffee pot in the Director of Nurse's office. Then again, a surge protector was powering a refrigerator in the MDS office. Based on interview at the time of each observation, the Maintenance Director acknowledged each aforementioned condition.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 1 flexible cords were not used as a substitute for fixed wiring. NFPA 70, National Electrical Code, 1999 Edition, Article 400-8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice affects staff only.</p> <p>Findings include:</p> <p>Based on observation with Maintenance Director on 05/04/16 at 12:30 p.m., an</p>		<p><i>alleged or conclusions set forth in the statement of deficiencies.</i></p> <p><i>The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p><b>1) Immediate actions taken for those residents identified:</b></p> <p>There were no residents cited in regard to this regulation.</p> <p><b>2) How the facility identified other residents:</b></p> <p>All residents, staff and visitors have the potential to be affected by the alleged deficient practice.</p> <p><b>3) Measures put into place/ System changes:</b></p> <p>The surge protectors in the Director of Nursing and MDS offices no longer power high current draw items.</p> <p>The extension cord found going into the ceiling has been replaced with an electrical line.</p> <p>Staff will be educated on the use of surge protectors by the Maintenance Director/designee by 6/3/16.</p> <p>Outside contractors will be educated, prior to completing services on the building, about proper regulations. The Maintenance Director/designee will inspect their work prior to job completion.</p> <p><b>4) How the corrective actions will be monitored:</b></p> <p>An Environmental QAPI tool will be utilized monthly to monitor compliance with proper smoke barrier walls. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until</p>	

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K 0000  Bldg. 02	<p>extension cord was going into the ceiling. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p> <p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 05/04/16</p> <p>Facility Number: 008505 Provider Number: 155580 AIM Number: 200064830</p> <p>At this Life Safety Code survey, Aperion Care Tolleston Park was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>This one story facility with a partial</p>	K 0000	100% compliance is achieved x3 consecutive months.		

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K 0025 SS=E Bldg. 02	<p>basement was determined to be of Type V (111) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors. Battery powered smoke detectors are located in the North and South wing resident rooms; the PCU resident rooms are equipped with hard wired smoke detectors. The facility has the capacity for 180 and had a census of 101 at the time of this survey.</p> <p>All areas where the residents have customary access were sprinklered. A detached wood equipment storage shed was unsprinklered.</p> <p>Quality Review completed on 05/06/16 - DA</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers shall be constructed to provide at least a one half hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels and steel frames. 8.3, 19.3.7.3, 19.3.7.5 Based on observation and interview, the facility failed to ensure 1 of 1 ceiling barriers and 3 of 10 smoke barrier walls were maintained to provide a 1/2 hour</p>	K 0025	<b>K025 NFPA 101 LIFE SAFETY CODE STANDARD The facility requests paper compliance for this citation.</b>	05/31/2016			

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	<p>fire resistance rating. LSC 8.3.2 requires smoke barriers shall be continuous from an outside wall to an outside wall. This deficient practice could affect staff and up to 28 residents.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director on 05/04/16 from 1:07 p.m. to 2:56 p.m., the following ceiling and smoke barrier wall penetration were discovered:</p> <p>a) one of five ceiling tiles were missing in the PCU clean linen room</p> <p>b) a one inch gap inside conduit going through the floor into the crawlspace in the PCU electrical room</p> <p>c) the smoke barrier near resident room 330 had drywall only on one side of the barrier. The other side of the barrier contained particle wood board.</p> <p>d) the smoke barrier near resident room 308 contained particle wood board and no drywall.</p> <p>Based on interview at the time of each observation, the Maintenance Director acknowledged and provided the measurements for each unsealed penetration.</p> <p>3.1-19(b)</p>		<p><i>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:</i></p> <p>The attic drywall has been repaired. · The unsealed penetration has been repaired and drywall has been repaired near Room 122. · The dining room penetration has been repaired. · The ceiling tile has been replaced in the PCU Clean Linen Room. · The gap in the conduit in the PCU Electrical Room has been repaired. · The drywall will be installed near Room 330. · The drywall will be installed near Room 308. 2) How the facility identified other residents: · All Residents, staff and visitors have the potential to be affected by the alleged deficient practice. 3) Measures put into place/ System changes: · Outside contractors will be educated, prior to completing services on the building, about proper fire wall penetrations. The Maintenance Director/designee will inspect for penetrations prior to job</p>				

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K 0029 SS=E Bldg. 02	<p>NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with o hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>Based on observation and interview, the facility failed to ensure the corridor door to 1 of 1 Storage Room 304, a hazardous area, was provided with self-closer and would latch into the frame. This deficient practice could affect staff and up to 12 residents.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director on 05/04/16 at</p>	K 0029	<p>completion. <b>4) How the corrective actions will be monitored:</b> · An Environmental QAPI tool will be utilized monthly to monitor compliance with proper smoke barrier walls. · 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.</p> <p><b>K 029 NFPA 101 LIFE SAFETY CODE STANDARD 1) Immediate actions taken for those residents identified:</b> · There were no residents cited in regard to this regulation. <b>2) How the facility identified other residents:</b> · All Residents, staff and visitors have the potential to be affected by the alleged deficient practice. <b>3) Measures put into place/ System changes:</b> · An automatic closure has been added to Room 304. All</p>	05/31/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155580	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>02</u> B. WING _____	X3) DATE SURVEY COMPLETED  05/04/2016
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NAME OF PROVIDER OR SUPPLIER  APERION CARE TOLLESTON PARK	STREET ADDRESS, CITY, STATE, ZIP CODE 2350 TAFT ST GARY, IN 46404
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K 0047 SS=E Bldg. 02	<p>1:20 p.m., storage room 304 contained nine mattresses, twelve wooden dressers, and other miscellaneous storage. The corridor failed to self-close and latch when tested. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 18.2.10.1, 19.2.10.1 (Indicate N/A in one story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) Based on observation and interview, the facility failed to ensure 1 of 1 exit signs above the East PCU exit door lead in the direction of the exit. LSC 7.10.1.4 requires access to exits shall be marked by approved, readily visible signs in all cases where the exit or way to reach the exit is not readily apparent to the occupants. This deficient practice could affect could affect staff, visitors, and up to 16 residents.</p> <p>Findings include:</p> <p>Based on an observation with the Maintenance Director on 03/05/15 at</p>	K 0047	<p>hazardous areas will have automatic door closures. 4. <b>How the corrective actions will be monitored:</b> Automatic closures are visually checked monthly and documented in the Preventative Maintenance Manual. The Executive Director will review the Preventative Maintenance Manual monthly. Findings will be presented to the Safety Committee for review.</p> <p><b>K047 NFPA 101 LIFE SAFETY CODE STANDARD 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:</b></p>	05/31/2016

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NAME OF PROVIDER OR SUPPLIER  APERION CARE TOLLESTON PARK			STREET ADDRESS, CITY, STATE, ZIP CODE 2350 TAFT ST GARY, IN 46404		
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K 0051 SS=E Bldg. 02	<p>1:25 p.m., the exit discharge near resident room 305 has a path go left and right. The left path goes back to a patio. The right path goes to the public way. No directional sign indicate which path should be traveled. Based on an interview at the time of observation, the Maintenance Director confirmed that occupants should be directed to the right sided path.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. Fire alarm system wiring or other transmission paths are monitored for integrity. Initiation of the fire alarm system is by manual means and by any required sprinkler system alarm, detection device, or detection system. Manual alarm boxes are provided in the path of egress near each required exit. Manual</p>		<p>There were no residents cited in regard to this regulation. <b>2)</b> <b>How the facility identified other residents:</b> · All Residents, staff and visitors have the potential to be affected by the alleged deficient practice. <b>3)</b> <b>Measures put into place/ System changes:</b> · A directional arrow has been added to the exit door near Room 305. An additional directional arrow has been added outside the exit door as well. · The Maintenance Director is responsible for compliance. <b>4)</b> <b>How the corrective actions will be monitored:</b> · Emergency exits are checked monthly and documented in the Preventative Maintenance Manual. The Executive Director will review the Preventative Maintenance Manual monthly. Findings will be presented to the Safety Committee for review.</p>		

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	<p>alarm boxes in patient sleeping areas shall not be required at exits if manual alarm boxes are located at all nurse's stations. Occupant notification is provided by audible and visual signals. In critical care areas, visual alarms are sufficient. The fire alarm system transmits the alarm automatically to notify emergency forces in the event of fire. The fire alarm automatically activates required control functions. System records are maintained and readily available. 18.3.4, 19.3.4, 9.6</p> <p>Based on observation and interview, the facility failed to ensure 3 of 4 300 Hall smoke detectors was not installed where air flow would adversely affect the operation. NFPA 72, 2-3.5.1 requires in spaces served by air handling systems, detectors shall not be located where air flow prevents operation of the detectors. This deficient practice could affect staff and up to 28 residents.</p> <p>Findings include:</p> <p>Based on observation with Maintenance Director on 05/04/16 between 1:05 p.m. and 1:32 p.m., the the following smoke detectors were less than thirty six inches from an HVAC vent:</p> <p>a) near resident room 313 was eighteen inches away b) near Human Resources office was eighteen inches away c) near resident room 323 was twenty inches away</p>	K 0051	<p><b>K051 NFPA 101 LIFE SAFETY CODE STANDARD</b> The facility requests paper compliance for this citation. <i>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.</i> <b>1) Immediate actions taken for those residents identified:</b> There were no residents cited in regard to this regulation. <b>2) How the facility identified other residents:</b> All Residents, staff and visitors have the potential to be affected by the alleged deficient practice. <b>3) Measures put into place/ System changes:</b> The smoke detectors were moved by</p>	05/31/2016

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	<p>Based on interview at the time of observation, the Maintenance Director acknowledged each aforementioned condition and provided the measurements.</p> <p>3.1-19(b)</p>		<p>room 313 and 323 as well as the Human Resources Office and are no longer less than thirty six inches from an HVAC vent. Outside contractors will be educated, prior to completing services on the building, about proper placement of the smoke detectors. The Maintenance Director/designee will inspect for proper placement prior to job completion. <b>4) How the corrective actions will be monitored:</b> Smoke detectors are checked quarterly and documented in the Preventative Maintenance Manual. The Executive Director will review the Preventative Maintenance Manual monthly. Findings will be presented to the Safety Committee for review</p>		