

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155572	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 06/10/2014
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NAME OF PROVIDER OR SUPPLIER APERION CARE DEMOTTE	STREET ADDRESS, CITY, STATE, ZIP CODE 10352 N 600 E COUNTY LINE RD DEMOTTE, IN 46310
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K010000	<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: 06/10/14</p> <p>Facility Number: 000471 Provider Number: 155572 AIM Number: 100290390</p> <p>Surveyor: Bridget Brown, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Autumn Hills Health and Rehab Center 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 was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in spaces open to the corridors. The facility has a capacity of 95 and had a census of 63 at the time of</p>	K010000		

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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K010025 SS=E	<p>this survey.</p> <p>All areas accessible to residents were sprinklered. A detached brick building housing the fire pump, emergency generator, and stored equipment and a wood storage shed were not sprinklered.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 06/17/14.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4</p> <p>Based on observation and interview, the facility failed to ensure openings through ceiling smoke barriers in 1 of 7 smoke</p>	K010025	Please accept this Plan of Correction as the	06/30/2014			

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	<p>compartments were sealed with a material to maintain the fire resistance of the ceiling smoke barrier. LSC Section 8.3.6.1 requires the passage of building service materials such as pipe, cable or wire to be protected so the space between the penetrating item and the smoke barrier shall be filled with a material capable of maintaining the smoke resistance of the smoke barrier or be protected by an approved device designed for the specific purpose. This deficient practice could affect visitors, staff and 10 or more residents in the center smoke compartment.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 06/10/14 at 12:00 p.m., two ceiling pipe penetrations in the "catch all" storage room accessed from an outside door were unsealed leaving half inch annular gaps around the pipe into the attic above. The maintenance director acknowledged at the time of observation, the penetrations had not been sealed.</p> <p>3.9-19(b)</p>		<p>facility's credible allegation of compliance. Submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by State and Federal regulations.</p> <p>1. Corrective actions taken and/or how the deficiency will be corrected:</p> <p>The "catch all" storage room pipe penetrations have been sealed.</p> <p>2. Actions the facility will take to ensure that no</p>				

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			<p>other examples of the deficiency</p> <p>exists in other parts of the building :</p> <p>The Maintenance Director has examined all areas of the building's throughout the facility to ensure that no other examples of this deficiency exist in other parts of the building .</p> <p>3. Measures put in place or systemic changes made to ensure that the deficient practice will not recur:</p> <p>To ensure on-going</p>		

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			<p>compliance, monthly inspections will be conducted by the Maintenance Director /Designee times three months to ensure that all penetrations remain sealed.</p> <p>4. Quality Assurance Plans to monitor performance and ensure that solutions are sustained :</p> <p>Monthly Audits times three months of QA tools will be conducted by the HFA/Designee to ensure compliance. System performance will be reviewed at the monthly QA meeting until resolution is achieved .</p>	

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K010038 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p> <p>Based on observation and interview, the facility failed to ensure 2 of 3 means of exit were provided with latches readily operated under all lighting conditions. LSC 7.2.1.5.4. requires where a latch or other similar device is provided, the method of operation of its releasing device must be obvious, even in the dark. The intention of this requirement is the method of release be one which is familiar to the average person. For example, a two step release, such as a knob and independent dead bolt, is not acceptable. In most occupancies, it is important that a single action unlatch the door. This deficient practice could affect visitors, staff and 19 residents on the West Hall.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 6/10/14 at 12:45 p.m., two different gates in a six foot privacy fence served as access to the</p>	K010038	<p>5.</p> <p>Please accept this Plan of Correction as the facility's credible allegation of compliance. Submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This plan of correction is submitted to meet requirements established by State and Federal Regulations.</p> <p>1. Corrective actions taken and/or how the deficiency will be corrected:</p>	06/30/2014			

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	<p>public way from the south exit on the west hall. Each gate was equipped with a latch at the top and the bottom of the gate. Each latch had to be opened in order to exit through the gates. The maintenance director agreed at the time of observation, more than a single action was required to exit through each of the gates.</p> <p>3.1-19(b)</p>		<p>Bottom latches removed from two privacy fence gates resulting in single action exit .</p> <p>2. Actions the facility will take to ensure that no other examples of the deficiency exist in other parts of the building :</p> <p>The Maintenance Director has examined all doors throughout the facility to</p> <p>Ensure that no other examples of this deficiency exist.</p>		

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			<p>3. Measures put in place or systemic changes made to ensure that the deficient practice will not recur:</p> <p>To ensure compliance, the Maintenance Director will conduct monthly QA rounds to ensure this deficiency does not recur.</p> <p>4. Quality Assurance plans to monitor performance and ensure that solutions are achieved :</p>		

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K010046 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9.19.2.9.1. Based on observation and interview, the facility failed to ensure the exterior exit discharge path for 2 of 9 discharges from emergency exits was provided with emergency powered egress lighting. LSC 7.9.1.1 requires emergency lighting be provided for means of egress, including	K010046	To ensure compliance, the Maintenance Director will conduct monthly QA rounds time three months. The Administrator/Maintenance Director and or designee will monitor compliance through QA rounds. System performance will be reviewed at the Quality Assurance Committee meeting monthly times three months until resolution has been achieved . Please accept this Plan of Correction as the facility's credible allegation of compliance. Submission of this plan is not an admission that a deficiency exists or that one was cited properly. This plan of correction is submitted	06/30/2014

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	<p>walkways leading to a public way. This deficient practice affects visitors, staff and 19 residents on the west hall.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 06/10/14 at 12:45 p.m., two south exit discharge paths from the fenced enclosure outside the south exit on the west wing were not provided with emergency lighting. The maintenance director agreed at the time of observation, these exit discharges had no emergency lighting.</p> <p>3.1-19(b)</p>		<p>to meet requirements established by State and Federal Regulations.</p> <p>1. Corrective actions taken and/or how the deficiency will be corrected:</p> <p>The two south exit discharge paths are provided with emergency lighting per generator back-up.</p> <p>2. Actions the facility will take to ensure that no other examples of the deficiency exist in any other parts of the building:</p> <p>The Maintenance Director has examined all exterior paths throughout the facility to ensure that no other examples of this deficiency exists in other parts of the building.</p> <p>3. Measure put in place or systemic changes made to ensure that the deficient practice will</p>		

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K010048 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1 Based on record review and interview,	K010048	<p>not recur:</p> <p>To ensure compliance, the Maintenance Director will conduct audits to ensure that all exits are laminated.</p> <p>4. Quality Assurance plans to monitor performance and ensure that solutions are achieved:</p> <p>To ensure compliance, the Maintenance Director will conduct audits times three months to ensure that all exits are laminated. The Administrator/Maintenance and/or Designee, will monitor compliance through QA rounds. System performance will be reviewed at the Quality Assurance Committee Meeting until resolution has been achieved.</p>	06/30/2014	

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	<p>the facility failed to provide a fire plan which included the identification of and evacuation of the smoke compartment in the written fire plan for the protection of 63 of 63 residents. LSC 19.7.2.2 requires a written health care occupancy fire safety plan shall provide for the following:</p> <ol style="list-style-type: none"> 1. Use of alarms. 2. Transmission of alarms to fire department. 3. response to alarms. 4. Isolation of fire. 5. Evacuation of immediate area. 6. Evacuation of smoke compartment. 7. Preparation of floors and building for evacuation. 8. Extinguishment of fire. <p>This deficient practice affects all residents, staff and visitors in the event of an emergency.</p> <p>Findings include:</p> <p>Based on record review with the maintenance director on 06/10/14 at 2:25 p.m., the Facility Fire Plan and Procedures was incomplete. There was no direction to remove endangered residents to another smoke compartment if indicated, and no identification of smoke zones as places of refuge and their location. The maintenance director acknowledged at the time of record</p>		<p>Please accept this Plan of Correction as the facility's credible allegation of compliance. Submission of this plan is not an admission that a deficiency exists or that one was cited properly. This plan of correction is submitted to meet requirements established by State and Federal Regulations.</p> <p>1. Corrective actions taken and/or how the deficiency will be corrected:</p> <p>Facility Fire Plan and Procedure has been revised to include the identification of smoke compartments and their use.</p> <p>2. Actions the facility will take to ensure that no other examples of the deficiency exist in</p> <p>any other parts of the building:</p> <p>The Maintenance Director has ensured that all deficiencies to the Facility Fire Plan and Procedure were corrected and</p>				

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	review, identification of smoke compartments and their use was not addressed in the fire plan. 3.1-19(b)		<p>installed in the Fire Safety Manuel to ensure no other examples of this deficiency exist in the building. All staff to be in-serviced on updated Facility Fire Plan and Procedure</p> <p>3. Measure put in place or systemic changes made to ensure that the deficient practice will not recur:</p> <p>To ensure compliance, the Maintenance Director will update the Fire Safety Manuel Annually with any new changes.</p> <p>4. Quality Assurance plans to monitor performance and ensure that solutions are achieved:</p> <p>The Administrator/Maintenance and/or Designee, will monitor compliance through QA rounds. System performance will be reviewed at the Quality Assurance Committee Meeting</p>		

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K010062 SS=F	<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>1. Based on record review and interview, the facility failed to perform weekly sprinkler system fire pump tests on 1 of 1 fire pumps. NFPA 25, 5-3.2.1 requires a weekly test of electric motor driven pump assemblies shall be conducted without flowing water. This test shall be conducted by starting the pump automatically. The pump shall run a minimum of 10 minutes. This deficient practice could affect all staff, visitors and residents.</p> <p>Findings include:</p> <p>Based on review of facility sprinkler system preventive maintenance records and contractor reports of sprinkler system Reports of Inspection with the maintenance director on 06/10/14 at 2:15 p.m., evidence of weekly fire pump maintenance testing was not found. The maintenance director confirmed at the time of record review, the weekly testing was not done.</p>	K010062	<p>until resolution has been achieved.</p> <p>Please accept this Plan of Correction as the facility's credible allegation of compliance. Submission of this plan is not a admission that a deficiency exists or that one was cited properly. This plan of correction is submitted to meet requirements established by State and Federal Regulations.</p> <p>1. Corrective actions taken and/or how the deficiency will be corrected:</p> <p>A. Electric motor-driven pump assemblies will be tested weekly.</p> <p>B. All stored items stored in the generator building have been removed and Relocated</p>	06/30/2014			

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	<p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure the fire pump assembly would not be subject to physical damage. NFPA 25, 5-2.1 requires inspection of the pump assembly to ensure it is free from physical damage. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on observation of the fire pump assembly location with the maintenance director on 06/10/14 at 12:45 p.m., the fire pump was located in a building separate from the facility. The building housed the emergency generator and was filled to capacity with chairs, rails, and miscellaneous maintenance equipment too numerous to count. Additionally, garden implements and a wheel barrow were located in the space. The items abutted the fire pump and prevented access without removing stored items from the room. The maintenance director agreed at the time of observation, the equipment was stored haphazardly and could likely cause damage to the fire pump assembly.</p> <p>3.1-19(b)</p>		<p>to an off-site storage unit.</p> <p>C. All exterior sprinkler heads are clean, inspected, and free from corrosion.</p> <p>D. External loads have been removed from sprinkler riser.</p> <p>2. Actions the facility will take to ensure that no other examples of the deficiency exist in</p> <p>any other parts of the building:</p> <p>A. The Maintenance Director will monitor all electric motor-driven pumps throughout the facility to ensure that no other examples of this deficiency exist in other parts of the building.</p> <p>B. The Maintenance Director has examined all storage areas that are separate from the facility to ensure that the facility does not have any storage areas with this deficiency.</p>		

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	<p>3. Based on observation and interview, the facility failed to ensure 4 of 4 sprinkler heads under the main entrance/exit canopy were free of corrosion. NFPA 25, 2-2.1.1 requires sprinklers to be free of foreign materials and corrosion. This deficient practice affects staff, visitors and 10 or more residents in the east smoke compartment.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 06/10/14 at 11:30 a.m., four sprinkler heads under the main entrance/exit canopy had turned green, usually evidence of corrosion. The maintenance director agreed at the time of observation, the sprinkler heads were showing evidence of corrosion.</p> <p>3.1-19(b)</p> <p>4. Based on observation and interview, the facility failed to ensure piping for 1 of 1 automatic sprinkler systems was maintained free of external loads. NFPA 25, 2-2.2 requires sprinkler piping shall be not be subjected to external loads by materials either resting on the pipe or hung from the pipe. This deficient practice affects all occupants.</p>		<p>C. The Maintenance Director has examined all exterior sprinkler heads to ensure that the facility does not have any corroded sprinkler heads with this deficiency.</p> <p>D. The Maintenance Director has examined all sprinkler pipes to ensure that facility does not have any other areas with this deficiency.</p> <p>3. Measure put in place or systemic changes made to ensure that the deficient practice will not recur:</p> <p>A. To ensure compliance, the Maintenance Director will conduct weekly sprinkler system fire pump tests, and record results on 'Exhibit A'.</p> <p>B. To ensure compliance, the Maintenance Director will conduct monthly, times three months, QA rounds to ensure</p>				

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	<p>Findings include:</p> <p>Based on observation with the maintenance director on 06/10/14 at 12:35 p.m., the sprinkler pipe for the sprinkler riser in the maintenance room was had a coiled garden hose on it as well as a tool box and piece of maintenance equipment. The pipe supplied water to the riser for sprinklers throughout the system. The maintenance director acknowledged at the time of observation, sprinkler piping should not be subject to external loads of any kind.</p> <p>3.1-19(b)</p>		<p>that the facility does not have any storage areas with this deficiency.</p> <p>C. To ensure compliance, the Maintenance Director will conduct quarterly inspections of all exterior sprinkler heads to ensure that the facility does not have any areas with this deficiency.</p> <p>D. To ensure compliance, the Maintenance Director will ensure weekly, times three months, that no external loads are placed on sprinkler riser, and that the facility does not have any areas with this deficiency.</p> <p>4. Quality Assurance plans to monitor performance and ensure that solutions are achieved:</p> <p>HFA to in-service Maintenance Director to keep external loads off sprinkler riser. The Administrator/Maintenance and/or Designee will monitor compliance through QA</p>		

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K010067 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2</p> <p>Based on observation, record review and interview; the facility failed to ensure dampers in the ductwork serving 7 of 7 smoke compartments were inspected and provided necessary maintenance at least every four years in accordance with NFPA 90A. LSC 9.2.1 requires air conditioning, heating, ventilating ductwork and related equipment shall be in accordance with NFPA 90A, Standard for the Installation of Air-Conditioning and Ventilating Systems. NFPA 90A, 1999 Edition, 3.4.7, Maintenance, requires at least every 4 years, fusible links (where applicable) shall be removed; all dampers shall be operated to verify they fully close; the latch, if provided, shall be checked, and moving parts shall be lubricated as necessary. This deficient practice affects all occupants.</p>	K010067	<p>rounds. System performance will be reviewed at the Quality Assurance Committee meeting until resolution has been achieved.</p> <p>Please accept this Plan of Correction as the facility's credible allegation of compliance. Submission of this plan is not a admission that a deficiency exists or that one was cited properly. This plan of correction is submitted to meet requirements established by State and Federal Regulations.</p> <p>1. Corrective actions taken and/or how the deficiency will be corrected:</p> <p>Smoke barrier fire dampers will be tested every four years in accordance with NFPA. Smoke barrier fire dampers are scheduled to be tested on 7/01/2014.</p>	07/02/2014	

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	<p>Findings include:</p> <p>Based on observation on 06/10/14 between 11: 30 a.m. and 2:05 p.m., ducts on all halls were equipped with smoke dampers. Based on review of facility maintenance, preventive maintenance and testing records with the maintenance director on 06/10/14 at 3:25 p.m., no inspection and tests of smoke barrier fire dampers was found. The maintenance director said at the time of record review, the dampers had not been tested since he arrived one year ago and he had no record of their testing.</p> <p>3.1-19(b)</p>		<p>2. Actions the facility will take to ensure that no other examples of the deficiency exist in</p> <p>any other parts of the building:</p> <p>To ensure that no other examples of this deficiency exist in the building, the Maintenance Director will ensure inspections are scheduled with SafeCare every 4 years to ensure smoke barrier fire dampers are tested.</p> <p>3. Measure put in place or systemic changes made to ensure that the deficient practice will</p> <p>not recur:</p> <p>To ensure compliance, the Maintenance Director will schedule testing for smoke barrier fire dampers every four years, to ensure that the facility does not have any smoke barrier fire dampers with this deficiency.</p>		

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K010076 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities.</p> <p>(a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation.</p> <p>(b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 cylinders of nonflammable gases was properly stored; chained or supported in a cylinder stand or cart. NFPA 99, Health Care Facilities, 8-3.1.11.2(h) requires cylinder or</p>	K010076	<p>4. Quality Assurance plans to monitor performance and ensure that solutions are achieved:</p> <p>The Administrator/Maintenance and/or Designee will monitor compliance through QA rounds. System performance will be reviewed at the Quality Assurance Committee meeting until resolution has been achieved.</p> <p>Please accept this Plan of Correction as the facility's credible allegation of compliance. Submission of this plan is not an admission that a deficiency exists or that</p>	06/30/2014	

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	<p>container restraints 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 visitors, staff and 10 or more residents in east smoke compartment.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 06/10/14 at 12:00 p.m., one oxygen e-cylinder was stored without support in the general storage room accessed from outside the center smoke compartment. The maintenance director said at the time of observation, the cylinder "had to go back", "they" hadn't had it picked up yet.</p> <p>3.1-19(b)</p>		<p>one was cited properly. This plan of correction is submitted to meet requirements established by State and Federal Regulations.</p> <p>1. Corrective actions taken and/or how the deficiency will be corrected:</p> <p>All E-Cylinders in general storage room are supported properly in a cylinder cart. Cylinder found in general storage room has been removed and placed in proper container.</p> <p>2. Actions the facility will take to ensure that no other examples of the deficiency exist in</p> <p>any other parts of the building:</p> <p>The Maintenance Director has examined all storage rooms throughout the Facility to ensure that no other examples of this deficiency exist in other parts of the building.</p>		

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			<p>3. Measure put in place or systemic changes made to ensure that the deficient practice will not recur:</p> <p>To ensure compliance, the Maintenance Director/HFA will ensure cylinder carts are readily available for proper storage of all E-Cylinders.</p> <p>4. Quality Assurance plans to monitor performance and ensure that solutions are achieved:</p> <p>To ensure compliance, the Maintenance Director will conduct weekly audits time three months to ensure that the facility does not have any cylinders not properly stored. Staff to be in-serviced on proper E-Cylinder storage.</p> <p>The Administrator/Maintenance and/or designee, will monitor compliance through QA rounds. System performance</p>		

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K010144 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.</p> <p>Based on observation and interview, the facility failed to prevent storage accumulation in 1 of 1 generator rooms in accordance with NFPA 101, 2000 Edition, Life Safety Code. LSC Section 7.9.2.3 requires emergency generators providing power to emergency lighting systems shall be installed, tested, and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. NFPA 110 Section 5-11.1 requires the room in which the EPS (Emergency Power Supply) equipment located shall not be used for storage purposes. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observation with maintenance director on 06/10/14 at 11:40 a.m., the emergency generator was located in a generator building separate from the</p>	K010144	<p>will be reviewed at the Quality assurance Committee meeting until resolution has been achieved.</p> <p>Please accept this Plan of Correction as the facility's credible allegation of compliance. Submission of this plan is not a admission that a deficiency exists or that one was cited properly. This plan of correction is submitted to meet requirements established by State and Federal Regulations.</p> <p>1. Corrective actions taken and/or how the deficiency will be corrected:</p> <p>All stored items stored in the generator building have been removed and Relocated to an off-site storage unit.</p> <p>2. Actions the facility will take</p>	06/30/2014			

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	<p>facility. The room was filled to capacity with patient care equipment, chairs, rails, wheel barrows, rakes and miscellaneous items too numerous to count. The stored items were located all around and abutted the generator set. A wheel barrow and several garden tools had to be removed to allow inspection of the generator and room for the maintenance director to demonstrate its operation. The maintenance director said at the time of observation, he could not keep the room clear of storage brought in by other facility employees.</p> <p>3.1-19(b)</p>		<p>to ensure that no other examples of the deficiency exist in</p> <p>any other parts of the building:</p> <p>The Maintenance Director has examined all storage areas that are separate from the facility to ensure that the facility does not have any storage areas with this deficiency.</p> <p>3. Measure put in place or systemic changes made to ensure that the deficient practice will</p> <p>not recur:</p> <p>To ensure compliance, the Maintenance Director will ensure that all excess of stored items will now be stored in off-site storage units.</p> <p>4. Quality Assurance plans to monitor performance and ensure that solutions are</p> <p>achieved:</p>	

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K010147 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>Based on observation and interview, the facility failed to ensure an electrical equipment room in 1 of 7 smoke compartments was provided with sufficient access and working space to permit ready and safe operation and maintenance of the equipment. NFPA 70, Article 110.26 requires sufficient access and working space shall be provided and maintained about all electrical equipment to permit ready and safe operation and maintenance of such equipment. Table 110.26 (A)(1) requires</p>	K010147	<p>To ensure compliance, the Maintenance Director will conduct monthly, times three months, QA rounds to ensure that the facility does not have any storage areas with this deficiency. The Administrator/Maintenance and/or Designee will monitor compliance through QA rounds. System performance will be reviewed at the Quality Assurance Committee meeting until resolution has been achieved. All staff to be in-serviced on proper use of storage room.</p> <p>Please accept this Plan of Correction as the facility's credible allegation of compliance. Submission of this plan is not an admission that a deficiency exists or that one was cited properly. This plan of correction is submitted to meet requirements established by State and Federal Regulations.</p> <p>1. Corrective actions taken</p>	06/30/2014	

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	<p>a minimum of three feet of clear distance from the electrical equipment. This deficient practice affects visitors, staff and 10 or more residents in the west center and north smoke compartments.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 06/10/14 between 11:30 a.m. and 2:30 p.m.:</p> <p>a. Three electrical panels in the generator building were inaccessible due to the storage of gardening equipment such as a wheel barrow, rakes and shovels and other miscellaneous equipment stored in front of the panels;</p> <p>b. Two electrical panels and two transfer switch panels in the "general storage room" were blocked by the miscellaneous equipment stored there;</p> <p>c. Electrical panels and transfer switches in the maintenance shop were blocked by maintenance supplies and equipment.</p> <p>The maintenance director acknowledged at the time of observations, the electrical panels should have been kept clear of the items blocking access to these panels.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 4 of 4 flexible cords and/or multitap adapters were not</p>		<p>and/or how the deficiency will be corrected:</p> <p>A. All stored items in the generator building have been removed and relocated to an off-site storage unit, providing access to three electrical panels.</p> <p>B. All stored items in the generator building have been removed and relocated to an off-site storage unit, providing access to two electrical panels, and two transfer switch panels.</p> <p>C. All stored items in the maintenance shop have been cleared, providing access to electrical panels, and transfer switch panels.</p> <p>2. Actions the facility will take to ensure that no other examples of the deficiency exist in</p> <p>any other parts of the building:</p> <p>A. The Maintenance Director</p>		

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	<p>used as a substitute for fixed wiring. NFPA 70, the National Electrical Code, 1999 Edition, Article 400-8 requires, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect staff, visitors and 13 or more residents in the west and center smoke compartments.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 06/10/14 between 11:30 a.m. and 2:30 p.m.:</p> <p>a. An extension cord was piggybacked to a power strip in resident room 23;</p> <p>b. Multi tap adapters powered office equipment in the social services office and a refrigerator and microwave in the physical therapy department;</p> <p>c. An extension cord powered the automatic chemical dispensing equipment in the laundry. The maintenance director agreed at the time of observations, the adapters and cords had been incorrectly used in this manner.</p> <p>3.1-19(b)</p>		<p>has examined all storage areas that are separate from the facility to ensure that the facility does not have any storage areas with this deficiency.</p> <p>B. The Maintenance Director has examined all storage areas that are separate from the facility to ensure that the facility does not have any storage areas with this deficiency.</p> <p>C. The Maintenance Director has examined the Maintenance Shop to ensure that this area does not have any areas with this deficiency.</p> <p>3. Measure put in place or systemic changes made to ensure that the deficient practice will not recur:</p> <p>A. To ensure compliance, the Maintenance Director will conduct monthly, times three</p>		

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			<p>months, to ensure that the facility does not have any storage areas with this deficiency.</p> <p>B. To ensure compliance, the Maintenance Director will conduct monthly, times three months, to ensure that the facility does not have any storage areas with this deficiency.</p> <p>C. To ensure compliance, the Maintenance Director will conduct weekly audits, times three months, to ensure that the Maintenance Shop does not have any areas with this deficiency.</p> <p>4. Quality Assurance plans to monitor performance and ensure that solutions are achieved:</p> <p>The Administrator/Maintenance and/or Designee will monitor compliance through QA rounds. System performance will be reviewed at the Quality Assurance Committee meeting</p>		

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			<p>until resolution has been achieved.</p> <p>Please accept this Plan of Correction as the facility's credible allegation of compliance. Submission of this plan is not an admission that a deficiency exists or that one was cited properly. This plan of correction is submitted to meet requirements established by State and Federal Regulations.</p> <p>1. Corrective actions taken and/or how the deficiency will be corrected:</p> <p>A. Extension cord in Room 23 was removed. Family was educated on use of extension cords.</p> <p>B. Multi-tap adapters powering office equipment in the Social Services Office, and a refrigerator and microwave in the Physical Therapy Department have been removed.</p> <p>C. Extension cord powering automatic chemical dispensing equipment in the Laundry Room has been removed and replaced with wall outlet.</p> <p>2. Actions the facility will take to ensure that no other examples of the deficiency</p>		

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			<p>exist in any other parts of the building:</p> <p>A. The Maintenance Director has examined all rooms throughout the facility to ensure that no other examples of this deficiency exist in all other parts of the building.</p> <p>B. The Maintenance Director has examined all rooms throughout the facility to ensure that the facility does not have any areas with this deficiency.</p> <p>C. The Maintenance Director has examined the Laundry Room to ensure that this area does not have any areas with this deficiency.</p> <p>3. Measure put in place or systemic changes made to ensure that the deficient practice will not recur:</p> <p>A. To ensure compliance, the Maintenance Director will conduct weekly audits, times three months, to ensure that the facility does not have any rooms with this deficiency.</p> <p>B. To ensure compliance, the Maintenance Director will conduct weekly audits, times</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155572	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 06/10/2014
NAME OF PROVIDER OR SUPPLIER APERION CARE DEMOTTE			STREET ADDRESS, CITY, STATE, ZIP CODE 10352 N 600 E COUNTY LINE RD DEMOTTE, IN 46310		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	
			<p>three months, to ensure that the facility does not have any areas with this deficiency.</p> <p>C. To ensure compliance, the Maintenance Director will conduct weekly audits, times three months, to ensure that the Laundry Room does not have any areas with this deficiency.</p> <p>4. Quality Assurance plans to monitor performance and ensure that solutions are achieved:</p> <p>The Administrator/Maintenance and/or Designee will monitor compliance through QA rounds. System performance will be reviewed at the Quality Assurance Committee meeting until resolution has been achieved. All staff to be in-serviced regarding extension cord use and use of multi-tap adaptors, by June 30, 2014.</p>		