STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155064	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED 03/07/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE KOKOMO	3518 S LAFOUNTAIN ST KOKOMO, IN 46902

(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
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 483.70(a). Survey Date: 03/07/16 Facility Number: 000025 Provider Number: 155064 AIM Number: 100274850 At this Life Safety Code survey, Aperion Care-Kokomo 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. This one story facility was determined to be of Type II (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors and battery operated detectors in all resident sleeping rooms. The facility has a capacity of 105 and had a census of 70 at the time of this survey.	K 0000		

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered except for one detached garage and the one detached rental pod which provided facility storage and were not sprinklered. Quality Review completed on 03/15/16 - DA			
K 0025 SS=E Bldg. 01	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 5 smoke barriers were protected to maintain the one half hour fire resistance rating of the smoke barrier. LSC Section 8.3.6.1 requires the passage of building service materials such as pipe, cable or wire 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	K 0025	**K025** **The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.*	03/22/2016

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NAME OF PROVIDER OR SUPPLIER APERION CARE KOKOMO		STREET ADDRESS, CITY, STATE, ZIP CODE 3518 S LAFOUNTAIN ST KOKOMO, IN 46902	

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	purpose. This deficient practice could affect 24 residents on 300 hall if smoke from a fire were to infiltrate the protective barrier. Findings include: Based on observation on 03/07/16 at 2:30 p.m. with the Maintenance Supervisor the smoke wall located next to the laundry room had an exposed openings the size of a baseball at the upper and lower left side of the wall which were not firestopped. Based on interview on 03/07/16 at 2:34 p.m. with the Maintenance Supervisor, it was acknowledged the aforementioned smoke barrier wall had two openings which were not filled with a fire rated material to maintain a one half hour fire resistance rating. 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:** **The 24 residents on the 300 hall could be affected. Smoke wall was sealed with mortar to create firestop.** **2) How the facility identified other residents:** **All residents could be potentially affected by deficiency.**	

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			3) Measures put into place/ System changes: **Smoke wall identified was sealed with mortar in the 2 identified areas and verified by Maintenance Supervisor/designee. All facility smoke walls were inspected to verify compliance for fire resistance.** **4) How the corrective actions will be monitored:** **Maintenance supervisor/designee will monitor per facility preventive maintenance manual monthly. Any new openings, if any, will be repaired immediately to ensure compliance. Findings will be reported for 3 months to the Safety Committee and quarterly thereafter for 3 additional quarters.**	

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			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. **5) Date of compliance: 3/22/16**	
K 0046 SS=C Bldg. 01	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, the facility failed to provide documentation of a 30 second monthly functional test or a 90 minute annual functional test for 1 of 1 battery operated lights. NFPA 110, 5-3-1 requires lighting at the emergency generator. LSC Section 7.9.3 requires a functional test be conducted monthly for 30 seconds on every required emergency lighting system and annually for not less than 1 1/2 hours. This deficient practice could affect all occupants in the facility including staff, visitors and residents if emergency battery powered lights were not available.	K 0046	**K046** **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*	03/22/2016

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	Findings include: Based on Fire Safety Record review on 03/07/16 at 3:08 p.m. with the Maintenance Supervisor the facility tested the battery back up emergency light located in the Mechanical room on 300 hall, but did not document a thirty second monthly test or a ninety minute annual test. Based on interview concurrent with record review with the Maintenance Supervisor it was acknowledged the battery back up emergency light was checked monthly, but the documentation for the duration of the monthly and annual test was not documented. 3.1-19(b)		*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:** **Log book to document back up emergency light testing was created and hung next to emergency light. All residents, staff, and visitors could be affected if emergency light did not function properly. Light was functioning but log book was absent.** **2) How the facility identified other residents:** **All residents could potentially be affected by deficiency.**	

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			3) Measures put into place/ System changes: **Emergency Test Log binder was created and hung by emergency light to record light testing to ensure it works properly in case of emergency.** **4) How the corrective actions will be monitored:** **Facility maintenance supervisor/designee will test emergency light weekly for 30 seconds and 1 time annually for 90 minutes. All of the tests will be recorded in log book that is present at that site. Results will be reported to Safety Committee during monthly meeting.** 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. **5) Date of compliance: 3/22/16**	
K 0050 SS=F Bldg. 01	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 Based on record review and interview, the facility failed to conduct fire drills on all shifts for 2 of 4 quarters for 2015. This deficient practice affects all residents in the facility as well as staff and visitors. Findings include: Based on review of Monthly Fire Drill records on 03/07/16 at 3:45 p.m. with the Maintenance Supervisor, a fire drill report for the second shift of the first	K 0050	**K050** **The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.*	03/22/2016

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	quarter of 2015 and the third shift of the second quarter of 2015 was not available for review. Based on interview on 03/07/16 at 3:47 p.m. with the Maintenance Supervisor, it was acknowledged the fire drills for the aforementioned shifts of the first and second quarters of 2015 had not been done. 3.1-19(b) 3.1-51(c)		*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:** **All residents could be affected by incomplete fire drill log, as well as staff and visitors. All drills since the affected time period in first and second quarter of 2015 have been completed.** **2) How the facility identified other residents:** **All residents could potentially be affected by deficiency.**	

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			3) Measures put into place/ System changes: **Maintenance supervisor/designee will do fire drills monthly rotating shifts, so that all are covered quarterly. The result of drills will be recorded in the Fire Drill Log book per regulation. Maintenance supervisor/designee was in-serviced by Administrator explaining when, why, and how fire drills should be done and recorded.** **4) How the corrective actions will be monitored:** **Maintenance supervisor/designee will record all drills monthly for calendar year to ensure that fire drills are done correctly and recorded in Fire Drill Log book. Log book will be inspected monthly at Safety Committee meeting for 3 months and quarterly thereafter for 3 additional quarters to ensure compliance is achieved.**	

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			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. **5) Date of compliance: 3/22/16**	
K 0051 SS=F Bldg. 01	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 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.			

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	The fire alarm automatically activates required control functions. System records are maintained and readily available. 18.3.4, 19.3.4, 9.6 Based on observation and interview, the facility failed to properly test and maintain 1 of 1 fire alarm systems in accordance with NFPA 72. NFPA 72, 3-8.1 allows fire alarm system components to share control equipment or operate as stand alone systems, but in any case, they shall be arranged to function as a single system. NFPA 72, 1-5.4.6 requires trouble signals to be located in an area where it is likely to be heard. NFPA 72, 1-5.4.4 requires fire alarms, supervisory signals, and trouble signals to be distinctive and descriptively annunciated. NFPA 72, 5-5.3.2.1.6.1 requires the following: A DACT (Digital Alarm Communicator Transmitter) shall employ one of the following combinations of transmission channels: (1) Two telephone lines (numbers) (2) One telephone line (number) and one cellular telephone connection (3) One telephone line (number) and a one-way radio system (4) One telephone line (number) equipped with a derived local channel (5) One telephone line (number) and a one-way private radio alarm system (6) One telephone line (number) and a private microwave radio system	K 0051	**K051** **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:** **Koorsen Fire and Security was called to come inspect and repair connectivity to land phone line and fix no local trouble signal on fire alarm control panel. No trouble**	03/22/2016

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	(7) One telephone line (number) and a two-way RF multiplex system (8) A single integrated services digital network (ISDN) telephone line using a terminal adapter specifically listed for supervising station fire alarm service, where the path between the transmitter and the switched telephone network serving central office is monitored for integrity so that the occurrence of an adverse condition in the path shall be annunciated at the supervising station within 200 seconds. This deficient practice could affect all residents, staff and visitors. Findings include: Based on observation on 03/07/16 during the alarm test from 3:10 p.m. to 3:30 p.m. with the Maintenance Supervisor the DACT next to the fire alarm control panel (FACP) was placed in trouble from phone line failure. After more than 200 seconds there was no local trouble signal initiated to be seen or heard anywhere in the facility. Based on interview on 03/07/16 at 3:30 p.m. with the Maintenance Supervisor it was acknowledged a trouble signal was not initiated by the DACT. 3.1-19(b)		**signal could affect all residents, staff, and visitors.** **2) How the facility identified other residents:** **All residents could potentially be affected.** **3) Measures put into place/ System changes:** **Koorsen Fire Safety was called to the facility and repaired connectivity to the one land telephone line that goes along with our one cellular phone connection per NFPA 72. The Digital Alarm Communicator Transmitter was tested and proven to work in accordance with NFPA 72. Koorsen invoice #380787 dated 3/14/16 is proof that the system was checked and phone lines are operational. Koorsen Fire and Safety will continue to monitor quarterly the correct operation of the DACT system in conjunction**	

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			with maintaining our fire alarm panel per code. **4) How the corrective actions will be monitored:** **Koorsen Fire Safety reporting will be kept by Maintenance supervisor/designee for Life Safety regulation to ensure that quarterly checks are in place, performed, and duly noted as working satisfactorily per code. Koorsen work orders will be kept in an orderly file and made available to Safety Committee after quarterly visits and checked quarterly for 3 additional quarters.** 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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			x3 consecutive months. **5) Date of compliance: 3/22/16**	
K 0147 SS=E Bldg. 01	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 1. Based on observation and interview, the facility failed to ensure 3 of 9 powerstrips observed including extension cords and non-fused multiplug adapters were not used as a substitute for fixed wiring. LSC 19.5.1 requires utilities to comply with Section 9.1. LSC 9.1.1 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 1999 Edition. NFPA 70, Article 400-8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice would affect 24 residents on 300 hall as well as visitors and staff. Findings include: Based on observations on 03/07/16 during the tour from 12:00 pm. to 3:30 p.m. with the Maintenance Supervisor, the following was noted:	K 0147	**K147** **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.*	03/22/2016

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	a) A surge protector was used to power a oxygen concentrator in resident room 305. b) A surge protector was used to power a mini refrigerators in the dietary office and MDS office Based on interview with the Maintenance Supervisor at the time of observations during the tour surge protective devices were used with the oxygen concentrator and the mini refrigerators. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 3 of 3 electrical wires observed next to the washing machines in the laundry room were confined in a electrical junction box with a cover. NFPA 70, National Electrical Code, 1999 Edition, 1999 Edition, Article 370-28(c) requires exposed electrical wires be confined within a junction box with a cover compatible with the box. This deficient practice could affect 24 residents on 300 hall as well as visitors and staff. Findings include: Based on observation on 03/07/16 at 2:31 p.m. with the Maintenance Supervisor, a total of three electrical wires were		**1) Immediate actions taken for those residents identified:** **The 24 residents of 300 hall could be affected by deficient practices per K147. Three surge protectors were disconnected from an oxygen concentrator and two mini refrigerators and plugged directly into wall. Additionally, the 3 wires located in laundry area on same hall were put into a junction box.** **2) How the facility identified other residents:** **All residents could potentially be affected by deficiency.** **3) Measures put into place/ System changes:** **Maintenance supervisor/designee made sure oxygen concentrator in room 305 was plugged directly into wall, as well as two mini**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155064	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED 03/07/2016
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	exposed on the south wall in between two washing machines. The electrical wires could be turned on by pushing the breaker toggle switch to on. Based on interview on 03/07/16 concurrent with the observation it was acknowledged by the Maintenance Supervisor, the electrical wires described were exposed and not protected within a junction box with a cover. 3.1-19(b)		**refrigerators in dietary and MDS office. Junction box was used in laundry area to enclose 3 wires that were disconnected but not in an enclosed junction box.** **4) How the corrective actions will be monitored:** **Maintenance supervisor/designee will do weekly rounds in facility to ensure that no high voltage device is plugged into a surge protector. Additionally, any electrical work done by staff or contractor will be within National Electrical Code standards. Any identified areas of non-compliance will be immediately corrected. Audit of weekly rounds will be presented at monthly Safety Committee meeting for 3 months and quarterly for 3 quarters. Guardian Angel rounds 5 times per week by Dept. Heads, to ensure that electrical devices are connected correctly in resident rooms. Audit sheets kept in Administration office.**	

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			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. **5) Date of compliance: 3/22/16**	