

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155572	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/15/2015
--	---	---	---

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
K 000 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: 04/15/15</p> <p>Facility Number: 000471 Provider Number: 155572 AIM Number: 100290390</p> <p>At this Life Safety Code survey, Aperion Care DeMotte 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 spaces open to the corridors. The facility has the capacity for 93 and had a census of 59 at the time of this survey.</p>	K 000		

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155572	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/15/2015
--	---	---	---

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
K 014 SS=E Bldg. 01	<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 unsprinklered.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Interior finish for corridors and exitways, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and ceilings has a flame spread rating of Class A or Class B. 19.3.3.1, 19.3.3.2</p> <p>Based on observation and interview, the facility failed to ensure materials used as an interior finish for the corridor walls in 1 of 7 smoke compartments had a flame spread rating of Class A or Class B. LSC 101 10.2.3.2 states products required to be tested in accordance with NFPA 255, Standard Method of Test of Surface Burning Characteristics of Building Materials, shall be grouped in the following classes in accordance with their flame spread and smoke development.</p> <p>(a) Class A Interior Wall and Ceiling Finish. Flame spread 0-25; smoke development 0-450. Includes any material classified at 25 or less on the flame spread test scale and 450 or less on the smoke test scale. Any element</p>	K 014	<p>APERION CARE DEMOTTE</p> <p>PLAN OF CORRECTION K- 014</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 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>	05/08/2015

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 04/15/2015
--	---	--	---

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>thereof, when so tested, shall not continue to propagate fire.</p> <p>(b) Class B Interior Wall and Ceiling Finish. Flame spread 26-75; smoke development 0-450. Includes any material classified at more than 25 but not more than 75 on the flame spread test scale and 450 or less on the smoke test scale.</p> <p>(c) Class C Interior Wall and Ceiling Finish. Flame spread 76-200; smoke development 0-450. Includes any material classified at more than 75 but not more than 200 on the flame spread test scale and 450 or less on the smoke test scale. This deficient practice could affect visitors, staff and 10 or more residents in the Cottonwood smoke compartment.</p> <p>Findings include:</p> <p>Based on observation with the Administrator and Maintenance Director on 04/15/15 at 12:00 p.m., the lower half of the of the Cottonwood corridor halls was covered with carpet. The Administrator and Maintenance Director said after the time of observation, no documentation was available to demonstrate the carpeting exhibited a flame spread classification of Class A or B.</p>		<p>Documentation provided to demonstrate the carpeting on the lower half of Cottonwood corridor halls exhibits a flame spread classification of Class A or B.</p> <p>2. Actions the facility will take to ensure that no other examples of the deficiency exists in other parts of the building :</p> <p>The Maintenance Director has examined all corridor halls throughout the facility to ensure that no other examples of this deficiency exists 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>Administrator to ensure documentation is available upon request regarding carpet on the lower half of Cottonwood corridor walls exhibit a flame spread classification of Class A or B.</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 04/15/2015
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	
K 018 SS=E Bldg. 01	3.1-19(b) NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities.		4. Quality Assurance plans to monitor performance and to ensure that solutions are achieved : The Administrator /Maintenance and/ or Designee, will monitor compliance QA rounds. Systemic performance will be reviewed at the Quality Assurance Committee meeting until resolution has been achieved . Completion Date: May 8, 2015		

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 04/15/2015
--	---	--	---

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>Based on observation and interview, the facility failed to ensure doors protecting openings into the corridor in 1 of 7 smoke compartments did not have an impediment to closing. This deficient practice could visitors, staff and 4 or more residents on the Clover hall.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director on 04/15/15 at 1:20 p.m., one door in the double door set protecting the corridor opening between the Clover hall dining room and adjacent exit corridor failed to close when tested twice to ensure its proper operation. The door coordinator on the door frame held the door with the astragal open, the second door closed and the coordinator failed to release the first door leaving a six inch gap. The Maintenance Director acknowledged at the time of observation, the coordinator was preventing the door from closing.</p> <p>3.1-19(b)</p>	K 018	<p>APERION CARE DEMOTTE</p> <p>PLAN OF CORRECTION K- 018</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 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>Maintenance Director repaired the coordinator for one door in the double door set protecting the corridor opening between the Clover Hall Dining Room on 4/17/2015.</p> <p>2. Actions the facility will take to ensure that no other examples of the deficiency exists in any other parts of the building:</p> <p>The Maintenance Director has examined all coordinators</p>	04/17/2015

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 04/15/2015
--	---	--	---

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>throughout facility to ensure that no other examples of this deficiency exists 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 compliance, the Maintenance Director and/or Designee will conduct weekly audits times three months to ensure that all coordinators are functioning properly.</p> <p>4. Quality Assurance plans to monitor performance and to ensure that solutions are achieved:</p> <p>The Administrator /Maintenance and /or designee, will monitor compliance QA rounds. System performance will be reviewed at the Quality Assurance Committee meeting until resolution has been achieved.</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 04/15/2015	
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			
K 038 SS=E Bldg. 01	<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>1. Based on observation and interview, the facility failed to ensure the means of egress through 3 of 7 exit doors were readily accessible. LSC 19.2.2.2.4 requires doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side. Exception No. 1 says door locking arrangements without delayed egress shall be permitted in health care occupancies, or portions of health care occupancies, where the clinical needs of the patients require specialized security measures for their safety, provided staff can readily unlock such doors at all times. This deficient practice affects visitors, staff and 10 or more residents on the Clover hall and the West hall.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director and Administrator on 04/15/15 between 11:50 a.m. and 1:15 p.m., all seven emergency exit doors were magnetically locked and would</p>	K 038	<p>Completion Date: April 17, 2015</p> <p>APERION CARE DEMOTTE</p> <p>PLAN OFCORRECTION K -038</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 is 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>All staff in serviced on 4/15/2015 regarding door codes' and successfully opening locked exit doors and padlocks.</p> <p>2. Actions the facility will take to ensure that no other examples of</p>	04/15/2015			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155572	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____		X3) DATE SURVEY COMPLETED 04/15/2015
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>unlock upon entering a code into a keypad on the wall adjacent to the door, interruption of power, and activation of the fire alarm system.</p> <p>(a) The West hall exit door is located on a locked unit where residents have diagnoses to warrant specialized security measures. However, at the time of observation, the Administrator was unable to enter the correct code and unlock the door and CNA #1 was unable to unlock the door and said she did not know the code. Nurse #1 was asked to demonstrate unlocking the same door and was able to do so.</p> <p>(b) The West hall exit door opens onto a covered patio surrounded by a six foot privacy fence with two padlocked gates. One or both gates are designated exits to the public way for evacuation purposes in an emergency. Nurse #1 was asked to demonstrate how the gates opened for evacuating residents after she successfully opened the locked exit door. She said she did not know how the padlocks were to be opened, did not know if there was a code or a key. She confirmed after learning these padlocks had a code to open them, she did not know the code. The Maintenance Director opened the locks using the codes for each padlock and the exit door keypad. He confirmed at the time of these observations and interviews, all</p>		<p>the deficiency exists in any other parts of the building :</p> <p>The Maintenance Director has examined all means of egress throughout the facility to ensure exit doors are readily accessible.</p> <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 an in-service upon hire with all employees regarding Door Codes and successfully opening locked exit doors.</p> <p>4. Quality Assurance plans to monitor performance and to ensure that solutions are achieved :</p> <p>The Administrator/Maintenance / HR Director will monitor compliance. System performance will be reviewed at the Quality Assurance Committee meeting until resolution has been achieved.</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 04/15/2015
--	---	--	---

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>staff on the hall could not open the door if the automatic override systems failed to disengage when indicated, and all staff did not have the special knowledge required to unlock the door and gates providing access to an evacuation point. (c) The codes for locked exit doors with adjacent keypad overrides were not posted for anyone without special knowledge of the code who had no clinical diagnosis requiring specialized security measures: on the locked Clover hall dining room and north Clover Hall exit doors where the code was posted as "same as side door." The administrator acknowledged at the time of observations, the posting of this information still required "special knowledge" to unlock the doors.</p> <p>3.1-19(b)</p> <p>b. The West hall exit door opens onto a covered patio surrounded by a six foot privacy fence with two padlocked gates. One or both gates are designated exits to the public way for evacuation purposes in an emergency. Nurse #1 was asked to demonstrate how the gates opened for evacuating residents after she successfully opened the locked exit door. She said she did not know how the padlocks were to be opened, did not know if there was a code or a key. She</p>		Completion Date: 4/15/2015	

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 04/15/2015
--	---	--	---

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>confirmed after learning these padlocks had a code to open them, she did not know the code. The Maintenance Director opened the locks using the codes for each padlock and the exit door keypad. He confirmed at the time of these observations and interviews, all staff on the hall could not open the door if the automatic override systems failed to disengage when indicated, and all staff did not have the special knowledge required to unlock the door and gates providing access to an evacuation point.</p> <p>c. The codes for locked exit doors with adjacent keypad overrides were not posted for anyone without special knowledge of the code who had no clinical diagnosis requiring specialized security measures: on the locked Clover hall dining room and north Clover Hall exit doors where the code was posted as "same as side door." The administrator acknowledged at the time of observations, the posting of this information still required "special knowledge" to unlock the doors.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 6 exit doors with a delayed egress lock was maintained. LSC 7.2.1.6.1 Delayed Egress Locks allows approved, listed,</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 04/15/2015
--	---	--	---

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>delayed egress locks, shall be permitted to be installed on doors serving low and ordinary hazard contents in buildings protected by a supervised automatic fire detection system installed in accordance with Section 9.6 or an approved or an approved supervised sprinkler system installed in accordance with 9.7, and where permitted in Chapters 12 through 42, provided:</p> <p>(a) The doors shall unlock upon actuation of an approved supervised automatic sprinkler system in accordance with Section 9.7 or upon the actuation of any heat detector or activation of not more than two smoke detectors of an approved, supervised automatic fire detection system in accordance with Section 9.6.</p> <p>(b) The doors shall unlock upon loss of power controlling the lock or locking mechanism.</p> <p>(c) An irreversible process shall release the lock within 15 seconds upon application of a force to release the device required in 7.2.1.5.4 that shall not be required to exceed 15 lbf (67 (N) nor be required to be continuously applied for more than 3 seconds. The initiation of the release process shall activate an audible signal in the vicinity of the door. Once the door lock has been released by application of force to the releasing device, relocking shall be by manual means only.</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 04/15/2015
--	---	--	---

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>Exception: Where approved by the authority having jurisdiction, a delay not exceeding 30 seconds shall be permitted.</p> <p>(d) On the door adjacent to the release device, there shall be a readily visible, durable sign in letters not less than 1 in. (2.5 cm) high and not less than 1/8 in. (0.3 cm) in stroke width on a contrasting background that reads: "PUSH Until ALARM SOUNDS. DOOR CAN BE OPENED IN 15 SECONDS".</p> <p>This deficient practice affects staff, visitors, and 10 or more residents in the South Hall.</p> <p>Findings include:</p> <p>Based on observation with the Administrator and Maintenance director on 04/15/15 at 12:15 p.m., the South Hall exit door was provided with a delayed egress lock and a sign stating the door could be unlocked after pushing on the door latch for 15 seconds. When force was applied to the releasing device on the door twice, an audible signal was not initiated and the door was not locked. The Maintenance Director said at the time of observation, the exit door magnetic lock was designed to release upon activation of the fire alarm, a power outage, a code entered into the keypad adjacent to the exit door and pushing the door for 15 seconds. He was unaware the</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 04/15/2015	
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
K 046 SS=C Bldg. 01	<p>lock was not working.</p> <p>3.1-19(b)</p> <p>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.</p> <p>Based on record review and interview, the facility failed to ensure 1 of 1 battery powered emergency lighting fixtures was tested annually for 1 1/2 hours. LSC 7.9.3 requires an annual test shall be conducted on every required battery powered emergency lighting system for not less than 1 1/2 hours. Written records of visual inspections and tests shall be kept. This deficient practice affects all occupants.</p> <p>Findings include:</p> <p>Based on review of facility fire safety inspection and test records with the Maintenance Director on 04/15/15 at 3:25 p.m., there was no record of an annual 1 1/2 hour test of the battery powered emergency light fixture in the emergency generator building. The Maintenance Director said at the time of record review, he had not done the test.</p> <p>3.1-19(b)</p>			K 046	<p>APERION CARE DEMOTTE</p> <p>PLAN OF CORRECTION K- 046</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 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 Maintenance Director conducted a 1 ½ test of the battery powered emergency light fixture in the emergency generator building on 4/16/2015.</p>		04/16/2015

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 04/15/2015
--	---	--	---

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>2. Actions the facility will take to ensure that no other examples of the deficiency exists in any other parts of the building:</p> <p>The Maintenance Director has tested all battery powered emergency light fixtures throughout the facility to ensure that no other examples of this deficiency exists in other parts of the building. The Administrator in-serviced the Maintenance Director regarding LSC 7.9.3 on 4/17/2015.</p> <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 and /or Designee will conduct annual testing of the emergency light fixtures in the emergency generator building.</p> <p>4. Quality Assurance plans to monitor performance and to ensure that solutions are achieved:</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 04/15/2015
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	
K 062 SS=E Bldg. 01	<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, the facility failed to ensure sprinkler heads providing protection for 6 of 6 smoke compartments were maintained. This deficient practice could affect all staff, visitors and residents.</p> <p>Findings include:</p> <p>Based on observation with the Administrator and Maintenance Director on 04/15/15 between 11:30 a.m. and 2:00 p.m.:</p> <p>a. One escutcheon for a sprinkler head protecting the plywood canopy over the</p>	K 062	<p>The Administrator /Maintenance Director and / or Designee, will monitor compliance QA rounds. System performance will be reviewed at the Quality Assurance Committee meeting until resolution has been achieved.</p> <p>Completion Date: April 16, 2015</p> <p>APERION CARE DEMOTTE PLAN OF CORRECTION K-144</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 correctly. This plan of correction is submitted to meet requirements established by State and Federal Regulations.</p>	04/17/2015	

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 04/15/2015
--	---	--	---

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>North Hall exit discharge was displaced, a second sprinkler head under the canopy had no escutcheon and a one inch gap was open into the interstitial space above.</p> <p>b. The sprinkler head protecting the West exit discharge canopy was green, usually evidence of corrosion. The Administrator and Maintenance director acknowledged the aforementioned conditions at the times of observation.</p> <p>3.1-19(b)</p>		<p>1. Corrective actions taken and/or how the deficiency will be corrected:</p> <p>The Maintenance Director performed a monthly generator load test on 4/17/2015.</p> <p>2. Actions the facility will take to ensure that no other examples of the deficiency exists in any other parts of the building:</p> <p>The Administrator to ensure that the Maintenance Director and / or Designee will perform the monthly generator load test as required by Life Safety Code.</p> <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 and or / Designee will conduct monthly generator load testing to ensure generator is functioning properly.</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 04/15/2015
--	---	--	---

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
K 144 SS=F Bldg. 01	<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 record review and interview, the facility failed to ensure a monthly load test for 1 of 1 emergency generators was conducted using one of the three following methods: under operating temperature conditions, at not less than 30% of the Emergency Power Supply (EPS) nameplate rating, or loading that maintains the minimum exhaust gas</p>	K 144	<p>4. Quality Assurance plans to monitor performance and to ensure that solutions are achieved:</p> <p>The Administrator /Maintenance and /or designee, will monitor compliance QA rounds. System performance will be reviewed at the Quality Assurance Committee meeting until resolution has been achieved.</p> <p>Completion Date: April 17, 2015</p> <p>APERION CARE DEMOTTE PLAN OF CORRECTION K- 147</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</p>	04/17/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155572	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/15/2015
--	---	---	---

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>temperatures as recommended by the manufacturer. Chapter 3-4.4.1.1 of NFPA 99 requires monthly testing of generators serving the emergency electrical system to be in accordance with NFPA 110. Chapter 6-4.2 of NFPA 110 requires generator sets in Level 1 and Level 2 service to be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods:</p> <p>a. Under operating temperature conditions or at not less than 30 percent of the EPS nameplate rating.</p> <p>b. Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer.</p> <p>The date and time of day for required testing shall be decided by the owner, based on facility operations. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on record review with the Maintenance Director on 04/15/15 at 3:40 p.m., records for the facility maintenance and testing of the emergency generator included a Weekly-Preventive Maintenance Two, Weekly Emergency Generator Test record prepared by the Maintenance Director and a two hour load bank test</p>		<p>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>Outlet removed on 4/17/2015 and a blank cover was installed.</p> <p>2. Actions the facility will take to ensure that no other examples of the deficiency exists in other parts of the building :</p> <p>The Maintenance Director has examined all other outlets throughout the facility to ensure that no other deficiency exists 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 compliance, The Maintenance Director has been in-serviced that prior to any further remodeling or electrical work that he will meet with contractors to ensure GFCI equipment is used in any wet locations .</p> <p>4. Quality Assurance plans to monitor performance and to ensure that solutions are achieved :</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155572	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/15/2015
--	---	---	---

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
K 147 SS=E Bldg. 01	<p>which was done by the emergency generator maintenance contractor. No record of monthly generator testing was provided for review. The Maintenance Director said at the time of record review, he did not do any monthly load testing.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 Based on observation and interview, the facility failed to ensure a wet location in 1 of 7 smoke compartments was provided with ground-fault circuit interrupter (GFCI) protection against electric shock. NFPA 70, Article 517, Health Care Facilities, defines wet locations as patient care areas subject to wet conditions while patients are present. These include standing fluids on the floor or drenching of the work area, either of which condition is intimate to the patient or staff. NFPA 70, 517-20 Wet Locations, requires all receptacles and fixed equipment within the area of the wet location to have GFCI protection. Moisture can reduce the contact resistance of the body, and electrical insulation is more subject to failure. This deficient practice could affect visitors,</p>	K 147	<p>The Administrator /Maintenance and/or designee, will monitor compliance QA rounds. System performance will be reviewed at the Quality Assurance Committee meeting until resolution has been achieved.</p> <p>Completion Date: April 17, 2015</p> <p>APERION CARE DEMOTTE</p> <p>PLAN OF CORRECTION K-062</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 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 Maintenance Director repaired the escutcheon for a sprinkler head protecting the plywood canopy over</p>	04/17/2015

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 04/15/2015
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>staff and any resident in the east central smoke compartment.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director and Administrator on 4/15/15 at 12:00 p.m., the electrical outlet in the bathroom located across from the East nurses station was 14 inches from the sink. The outlet was not provided with GFCI protection to prevent electric shock. The Maintenance Director said at the time of observation, there was no circuit panel GFCI for the outlet and the outlet should have had GFCI protection.</p> <p>3.1-19(b)</p>		<p>the North Hall exit on 4/17/2015. An escutcheon was placed under Second sprinkler head located under the canopy on 4/17/2015. The sprinkler head protecting the West exit discharge canopy was cleaned on 4/17/2015.</p> <p>2. Actions the facility will take to ensure that no other examples of the deficiency exists in any other parts of the building:</p> <p>The Maintenance Director has examined all sprinkler heads and escutcheons throughout the facility to ensure that no other examples of this deficiency exists 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 compliance, the Maintenance Director will conduct weekly audits times three months to ensure that facility is in compliance.</p> <p>4. Quality Assurance plans to monitor performance and to ensure that solutions are achieved:</p> <p>The Administrator / Maintenance and/or designee, will monitor compliance QA rounds. System performance will be reviewed at the</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/20/2015
FORM APPROVED
OMB NO. 0938-0391

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 04/15/2015
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	
			Quality Assurance Committee meeting until resolution has been achieved. Completion Date: April 17, 2015		