

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155277	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 01/07/2015
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NAME OF PROVIDER OR SUPPLIER APERION CARE VALPARAISO	STREET ADDRESS, CITY, STATE, ZIP CODE 3301 N CALUMET AVE VALPARAISO, IN 46383
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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: 01/07/15</p> <p>Facility Number: 000176 Provider Number: 155277 AIM Number: 100288940</p> <p>Surveyor: Bridget Brown, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Aperion Care Valparaiso 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 facility is located in two, two story buildings with walk out lower levels and connected by the "tunnel", a one story corridor. The two buildings, identified as the Pines and the Manor were determined to be of Type II (111) construction, built prior to March 1, 2003 and fully</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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K010021	<p>sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in all areas open to the corridor. The facility has battery operated smoke detectors in resident sleeping Rooms # 1 through # 37 on the Pines upper level and hard wired smoke detectors supervised by the fire alarm system in rooms 38 through 43 on the Pines lower level. Smoke detectors in resident sleeping rooms on the upper and lower level are hard wired.. The facility has the capacity for 146 and had a census of 95 at the time of this visit.</p> <p>All areas where the residents have customary access were sprinklered and all areas providing facility services were sprinklered.</p> <p>Quality Review by Dennis Austill, Life Safety Code Specialist on 01/12/15.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>						
	NFPA 101						

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SS=E	<p>LIFE SAFETY CODE STANDARD Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure is held open only by devices arranged to automatically close all such doors by zone or throughout the facility upon activation of:</p> <p>a) the required manual fire alarm system;</p> <p>b) local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and</p> <p>c) the automatic sprinkler system, if installed. 19.2.2.2.6, 7.2.1.8.2</p> <p>Based on observation and interview, the facility failed to ensure 1 of 3 Rehab Unit smoke barrier door sets were held open only by devices which would allow them to close upon activation of the fire alarm system. This deficient practice could affect staff, visitors, and 10 or more residents on the Manor Rehab unit.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director on 01/07/15 at 12:40 p.m., the double door set in the Rehab dining room smoke barrier was equipped with a door coordinator. The door set was tested twice to ensure its proper operation, and one door failed to close each time since the door coordinator held the door open. The fire alarm was tested on 01/07/15 at 12:45</p>	K010021	<p>K 021</p> <p>The facility requests paper compliance for this citation.</p> <p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>1) Immediate action taken for those residents identified: Door coordinator adjusted to allow door to close completely. *See attached photo. All facility doors</p>	01/30/2015	

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	p.m. with the same result. The Maintenance Director acknowledged at the time of observation, the doors could not prevent the passage of smoke. 3.1-19(b)		<p>with similar mechanisms were inspected to ensure proper closing.</p> <p>2) How the facility identified other possible doors: Visual inspections.</p> <p>3) Measures put into place/ System changes: Doors will be inspected monthly to ensure proper closure. *See Door Closure Audit Tool</p> <p>4) How the corrective actions will be monitored: Director of Maintenance will perform inspections and present findings to the Administrator or designee to sign.</p> <p>The results of these audits will be reviewed in Quality Assurance Meeting monthly x3 months, then quarterly x1 for a total of 6 months.</p> <p>5) Date of compliance: 1/21/15</p> <p style="text-align: center;">Door Close Audit</p> <p style="text-align: center;">Date</p> <p style="text-align: center;">Unit/Door</p>		

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			Pass/Fail Date Unit/Door Pass/Fail	

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K010022 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Access to exits is marked by approved,			

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	<p>readily visible signs in all cases where the exit or way to reach exit is not readily apparent to the occupants. 7.10.1.4</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 doors likely to be mistaken for a way of exit was identified as "No Exit." LSC 7.10.8.1 requires any door that is neither an exit nor a way of exit access and is located or arranged so it is likely to be mistaken for an exit shall be identified by a sign that reads: NO exit.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director on 01/07/15 at 2:25 p.m., an exit sign was located above the smoke barrier door separating upper Pines smoke compartment from the center smoke compartment. The sign was not illuminated. The Maintenance Director said at the time of observation, the south unit was closed and was not meant to be a means of emergency exit egress, he agreed the doorway could still be mistaken for a means of exit and should have been identified as "no exit."</p> <p>3.1-19(b)</p>	K010022	<p>K 022</p> <p>The facility requests paper compliance for this citation.</p> <p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>1) Immediate action taken for those residents identified: Exit sign was inspected and determined to be self-illuminating. *See attached photo. The Pines South unit has a stairwell that may be utilized as an emergency exit. *See attached photos.</p> <p>2) How the facility identified other emergency exits: All emergency exits signs were inspected for visibility and proper function. Director of Maintenance inspected on facility emergency</p>	01/30/2015

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			<p>exit locations. *See attached inservice.</p> <p>3) Measures put intoplace/ System changes: Director of Maintenance or designee will visuallyinspect all facility exit signs for proper function weekly. *See attached EmergencyLighting audit tool.</p> <p>4) How the corrective actions will be monitored: Directorof Maintenance will submit audits to the Administrator monthly for review.</p> <p>The results of these auditswill be reviewed in Quality Assurance Meeting monthly x3 months, then quarterlyx1 for a total of 6 months.</p> <p>5) Date ofcompliance: 1/21/15</p> <p style="text-align: center;">Emergency Lighting Testand Inspection Audit</p> <p style="text-align: center;">Date</p> <p style="text-align: center;">Location</p>		

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			Pass Y/N Date Location Pass Y/N	

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K010025 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD			

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	<p>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 ceiling and wall smoke barrier penetrations in 2 of 6 sprinklered smoke compartments were sealed in a manner which maintains the one half hour fire resistance rating. 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. LSC Section 8.3.2 requires smoke barriers to be continuous from floor to floor and outside wall to outside wall. This deficient could affect visitors, staff and 10 or more residents on the Rehab and Maple units and in areas adjacent to the kitchen.</p> <p>Findings include:</p>	K010025	<p>K 025</p> <p>The facility request paper compliance for this citation.</p> <p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>1) Immediate action taken for those residents identified: Identified non fire resistant caulk was removed and replaced with fire resistant caulk. *See attached photos.</p>	01/30/2015

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K010038	<p>Based on observation with the Maintenance Director between 11:15 a.m. and 2:45 p.m., ceiling and wall penetrations and gaps were found:</p> <p>a. Sealed with an unrated expandable foam in the Manor janitor's closet ceiling;</p> <p>b. 12 pipe penetration gaps sealed with an unrated expandable foam in the kitchen janitors closet ceiling;</p> <p>c. Sealed with an unrated expandable foam around the sprinkler pipe in the dietary locker room;conduit in the laundry;</p> <p>d. Sealed around a pipe penetration gap with an unrated expandable foam in the dietary chemical room.</p> <p>In addition, a two inch hole above the laid in ceiling in the smoke barrier in the Rehab unit and a half inch hole in the Maple clean utility room were unsealed.</p> <p>The maintenance director acknowledged the unrated material used to seal penetration gaps and unsealed gaps at the time of observations.</p> <p>3.1-19(b)</p> <p>NFPA 101</p>		<p>2) How the facility identified other areas: Visual inspection performed throughout facility to identify any additional penetrations lacking fire resistant caulk. Fire resistant caulk was applied where necessary.</p> <p>3) Measures put into place/ System changes: All Maintenance personnel educated as to proper caulk/sealant type to be used for smoke barrier penetrations.</p> <p>4) How the corrective actions will be monitored: Future maintenance projects that require that require smoke barrier penetration will be inspected by the Director of Maintenance or designee to insure appropriate fire resistant materials are used. A report noting same will be submitted to the Administrator.</p> <p>The results of these audits will be reviewed in Quality Assurance Meeting monthly x3 months, then quarterly x1 for a total of 6 months.</p> <p>5) Date of compliance: 1/30/15</p>		

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SS=F	<p>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 6 of 12 exits were arranged to minimize tripping hazards. LSC Section 7.1.6 requires walking surfaces in the means of egress shall comply with 7.1.6.4. LSC 7.1.6.4 requires walking surfaces to be nominally level. This deficient practice could affect visitors, staff and 40 or more residents evacuation the Pines and Manor buildings.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director on 01/07/15 between 11:15 a.m. and 2:25 p.m., the exit discharge surfaces for two east exits, and the southwest emergency exit from Pines, the east exit from the tunnel, physical therapy exit, and northwest Manor emergency exit were snow covered. The maintenance director said at the time of observation, some of the walks had been shoveled but acknowledged the snow covered surfaces were not safely accessible to any evacuation point.</p> <p>3.1-19(b)</p>	K010038	<p>K 038 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 action taken for those entry/exits identified: Snow cleared to allow doors to open and close and minimize trip hazard. Vegetation by Kitchen door removed. *See attached photo. Delayed door release repaired. 2) How the facility identified other entry/exits: Visually identified by maintenance personnel for snow accumulation, obstructions. All facility delay door releases checked for proper function. 3) Measures put into place/ System changes: Policy put in place to remove snow as necessary in order to allow proper function of exterior doors and provide a smooth</p>	01/30/2015			

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	<p>2. Based on observation and interview, the facility failed to ensure doors for 1 of 3 emergency exits to the outside from the kitchen could be opened. LSC 7.2.1.4 requires any door in a means of egress shall be installed so that it is capable of swinging from any position to the full required width of the opening in which it is installed. Additionally, 7.1.10.1 requires a means of egress shall be continuously maintained free of all obstructions or impediments to full and instant use in case of fire or other emergency. This deficient practice affects visitors, 4 or more kitchen staff and any resident in the adjacent smoke compartment.</p> <p>Findings include:</p> <p>Based on observation during a tour of the facility with the Maintenance Director on 01/07/15 at 12:05 p.m., the kitchen exit adjacent to the stove could not be opened more than eight inches before it became stuck. The Maintenance Director said at the time of observation it was blocked by snow and an overgrown tree.</p> <p>3. Based on observation and interview, the facility failed to ensure 1 of 12 exit doors with a sign notifying occupants of a delayed egress lock was readily accessible. LSC 7.2.1.6.1 Delayed</p>		<p>walkway. *See attached policy. Director of Maintenance or designee will clear snow from exterior doors after snow fall of 2 inches and as needed. Monthly door delay release function tests will be performed by Director of Maintenance or designee. *See attached audit tool. Weekly grounds check to be performed by Director of Maintenance or designee to assess for obstructing vegetative growth and/or any obstructions that may inhibit proper exterior door function or present a trip hazard. *See attached grounds audit tool. Findings will be presented to Administrator monthly for review. 4) How the corrective actions will be monitored: The results of these audits will be reviewed in Quality Assurance Meeting monthly x3 months, then quarterly x1 for a total of 6 months. 5) Date of compliance: 1/23/15 Doors Clear of Hazards Date Location Clear Y/N Date Location Clear Y/N</p>		

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	<p>Egress Locks allows approved, listed, 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</p>		<p>Exterior Door SnowRemoval Policy Aperioncare Valparaiso Snow events greater than 2 inches will require removal of snow by designated facility personnel to the extent necessary to allow external doors to open and close unimpeded. A chemical melting agent, such as rock salt, will also be applied when ice is observed.</p>	

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	<p>means only.</p> <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 adjacent lounge and dining areas.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director on 01/07/15 at 11:00 a.m., the main entrance for the upper level of Pines near the social services director's office was identified with a sign which notified occupants that the locked door would open with continuous pressure on the latch stile for 15 seconds. When force was applied to the door latch stile, an audible signal was not initiated and the door did not release. The door was tested twice to ensure the 15 second delay failed. The Maintenance Director said at the time of observation, he didn't even know if the door was actually equipped with a delayed egress</p>				

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K010046 SS=C	<p>lock. The door unlocked with a code entered into a keypad adjacent to the door.</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>1. Based on record review and interview, the facility failed to ensure battery powered emergency lighting fixtures for 2 of 2 buildings were tested for 30 seconds each month and annually for 1 1/2 hours. LSC 7.9.3 requires a functional test shall be conducted on every required battery powered emergency lighting system at 30 day intervals for not less than 30 seconds and an annual test shall be conducted 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 01/07/15 at</p>	K010046	<p>K 046</p> <p>The facility requests paper compliance for this citation.</p> <p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>1) Immediate action taken for those areas identified: Battery in fixture replaced. *See attached photo.</p>	01/30/2015

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	<p>3:25 p.m., there was no record of annual 1 1/2 hour or monthly 30 second test for any battery powered emergency lighting fixtures. The Maintenance Director said the time of record review, he had not known the test and documentation requirements for the battery powered emergency lighting fixtures.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 1 battery powered emergency light fixtures in the laundry would operate. LSC 7.9.2.5 requires battery operated emergency lights shall be capable of repeated automatic operation. This deficient practice affects visitors, staff and any resident in the adjacent corridor.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director on 01/07/15 at 1:20 p.m., the battery powered emergency light fixture in the laundry failed to illuminate when tested twice. The Maintenance Director said at the time of observation, he did not know the light fixture was not working.</p> <p>3.1-19 (b)</p>		<p>2) How the facility identified other potential deficiencies: Facility walk through by maintenance personnel to identify additional fixtures.</p> <p>3) Measures put into place/ System changes: Emergency light fixtures will be tested for 30 seconds monthly and 1 ½ hours annually by the Director of Maintenance or designee. A log will be put into place to record test dates and results. The log will be submitted to the Administrator monthly for review. *See attached Emergency Lighting audit tool.</p> <p>4) How the corrective actions will be monitored:</p> <p>The results of these audits will be reviewed in Quality Assurance Meeting monthly x3 months, then quarterly x1 for a total of 6 months.</p> <p>5) Date of compliance: 1/21/15 Emergency Lighting Test and Inspection Audit</p> <p>Date</p>				

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			<p style="text-align: center;">Location</p> <p style="text-align: center;">Pass Y/N</p> <p style="text-align: center;">Date</p> <p style="text-align: center;">Location</p> <p style="text-align: center;">Pass Y/N</p>	

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K010050 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD 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 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2</p> <p>Based on record review and interview, the facility failed to ensure fire drills were conducted quarterly on each shift for 2 of the last 4 quarters. This deficient practice could affect all residents, staff and visitors in the event of an emergency.</p> <p>Findings include:</p> <p>Based on review of the facility's Fire Drill Reports and interview with the Maintenance Director on 01/07/115 at 3:15 p.m., there was no record of a third shift fire drill for the first and fourth quarters of 2014. Evidence of a second shift fire drill during the fourth quarter of</p>	K010050	<p>K050</p> <p>The facility requestspaper compliance for this citation.</p> <p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p>	01/30/2015

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	<p>2014 was not found. The Maintenance Director acknowledged fire drill records were not complete and said he had provided all available fire drill documentation.</p> <p>3.1-9(b) 3.1-51(c)</p>		<p>1) Immediate actionstaken for issue identified: Director of Maintenance inserviced on quarterlyfire drills. *See Inservice attachment. *See K50 Audit Tool.</p> <p>2) How the facilityidentified other issues: No other fire drill issues noted.</p> <p>3) Measures put intoplace/ System changes: Administrator to be provided Fire Drill log on monthlybasis to review in order to ensure drills are done in a timely manner.</p> <p>4) How the corrective actions will be monitored:</p> <p>The results of these auditswill be reviewed in Quality Assurance Meeting monthly x3 months, then quarterlyx1 for a total of 6 months.</p> <p>5) Date ofcompliance: 1/30/15 K050</p> <p>AperioncareValparaiso</p>	

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			<p align="center">Life Safety Plan of Correction Audit Tool K50</p> <p align="center">To be completed by the Maintenance director or designee as fire drills are completed. Exact time should be put in open column for the correct shift/quarter.</p> <p align="center">Q1</p> <p align="center">Q2</p> <p align="center">Q3</p> <p align="center">Q4</p> <p>1st shift</p>	

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	<p>A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6</p> <p>Based on observation and interview, the facility failed to provide distinctive annunciation for 1 of 1 fire alarm systems in accordance with NFPA 72. NFPA 72, 1-5.4.4 Requires trouble signals shall be distinctively and descriptively annunciated. 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. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on interview with the Maintenance</p>	K010051	<p>K 051</p> <p>The facility requestspaper compliance for this citation.</p> <p><i>This Plan of Correction isthe center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correctiondoes not constitute admission or agreement by the provider of the truth of thefacts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/orexecuted solely because it is required by the provisions of federal and statelaw.</i></p> <p>1) Immediate actiontaken for the</p>	01/30/2015			

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	<p>Director on 01/07/15 at 2:10 p.m., the main fire alarm control panel (FACP) was annunciating a continuous sound thought to be associated with the communicating feature of the FACP earlier in the day. The sound had stopped without being identified. Based on observation, the fire alarm was tested at the time of interview and the monitoring station verified the receipt of the alarm. Then the two telephone lines were disconnected to put the main FACP panel into trouble to activate the audible trouble alarm. There was no audible alarm or LED light indicating trouble with the telephone lines providing notice of the failure of a communication feature of the fire alarm system. The Maintenance Director then called the monitoring station to verify their observation of the disconnection of the phone lines connected to the FACP. The monitoring station reported at the time there had been no trouble annunciated at the monitoring station that the phone lines were disconnected. The maintenance director acknowledged at the time of testing and follow up with the monitoring station, the communication telephone lines should have annunciated a local trouble alarm at the FACP and at the monitoring station to ensure no interruption of service.</p>		<p>equipment identified: Technician called. Technician reported that issue was likely a phone line issue, but not a phone line within the facility itself.</p> <p>2) How the facility identified other similar equipment: No similar equipment identified.</p> <p>3) Measures put into place/ System changes: Monitoring company installed wireless communication device. Monitoring company will call the facility to report any fault codes. Director of Maintenance or designee will contact monitoring company and test equipment as a part of scheduled fire drills. *See Fire Drill audit tool. The results will be submitted to the Administrator for review.</p> <p>4) How the corrective actions will be monitored:</p> <p>The results of these audits will be reviewed in Quality Assurance Meeting monthly x3 months, then quarterly x1 for a total of 6 months.</p> <p>5) Date of compliance: 1/30/15</p>	

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K010062 SS=F	<p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>Based on observation and interview, the facility failed to ensure sprinkler heads in the 2 of 10 use areas were free of corrosion and/or foreign materials, such as grime. NFPA 25, 2-2.1.1 requires sprinklers to be free of foreign materials and corrosion. This deficient practice affects kitchen staff and visitors and 10 or more residents in the Rehab smoke compartment.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director on 01/07/14 between 11:30 a.m. and 2:45 p.m., two sprinkler heads in the kitchen dishwashing area were turning green and were coated with a gray fuzzy material. Two sprinkler heads in the main kitchen food prep area and one sprinkler head in the Rehab Shower stall were coated with a gray fuzzy material. The Maintenance Director agreed at the time of observations, the foreign materials should not have collected on the sprinkler heads.</p>	K010062	<p>K 062</p> <p>The facility requests paper compliance for this citation.</p> <p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>1) Immediate action taken for those sprinklers identified: Gray material removed from all facility sprinklers.</p> <p>2) How the facility identified other sprinklers: Visual inspection.</p>	01/30/2015
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155277	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 01/07/2015
NAME OF PROVIDER OR SUPPLIER APERION CARE VALPARAISO			STREET ADDRESS, CITY, STATE, ZIP CODE 3301 N CALUMET AVE VALPARAISO, IN 46383		
(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	
	3.1-19(b)		<p>3) Measures put intoplace/ System changes: Monthly removal of gray material from sprinkler heads tobe performed by Maintenance. *See attached audit tool. Sprinklers will also beassessed at these times for green coloring. Sprinkler cleaning and inspectionlog will be submitted to Administrator monthly. Those sprinkler heads noted tohave green coloring at time of current survey are scheduled to be replaced by1/30/15.</p> <p>4) How the corrective actions will be monitored:</p> <p>The results of these auditswill be reviewed in Quality Assurance Meeting monthly x3 months, then quarterlyx1 for a total of 6 months.</p> <p>5) Date ofcompliance: 1/30/15 Sprinkler Inspectionand Cleaning</p> <p style="text-align: center;">Date</p> <p style="text-align: center;">Location</p> <p style="text-align: center;">Pass Y/N</p> <p style="text-align: center;">Date</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155277	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 01/07/2015
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NAME OF PROVIDER OR SUPPLIER APERION CARE VALPARAISO	STREET ADDRESS, CITY, STATE, ZIP CODE 3301 N CALUMET AVE VALPARAISO, IN 46383
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			<p>Location</p> <p>Pass Y/N</p>	

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K010064 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10 Based on observation and interview, the facility failed to ensure monthly checks were provided for 46 of 46 portable fire extinguishers. NFPA 10, the Standard for Portable Fire Extinguishers, Section 4-3.4.2 requires at least monthly, the date of inspection and the initials of the person performing the inspection shall be recorded. In addition NFPA 10, 4-2.1 defines inspection as a quick check that an extinguisher is available and will operate. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 01/07/15 between 11:15 a.m. and 2:45 p.m., the service and inspection tags on the portable fire extinguishers for all portable fire extinguishers in the facility each noted the last monthly check had been done 11/20/14. The Maintenance Director acknowledged at the time of observations, the fire extinguishers had not had monthly inspections since that date.</p>	K010064	<p>K 064</p> <p>The facility requests paper compliance for this citation.</p> <p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>1) Immediate action taken for those extinguishers identified: Extinguishers inspected.</p> <p>2) How the facility identified other extinguishers: All facility extinguishers visually identified and inspected.</p> <p>3) Measures put in place/ System</p>	01/30/2015
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	3.1-19(b)		<p>changes: Monthly inspections to be performed by Director of Maintenance or designee. *See audit tool. Results will be provided to Administrator.</p> <p>4) How the corrective actions will be monitored:</p> <p>The results of these audits will be reviewed in Quality Assurance Meeting monthly x3 months, then quarterly x1 for a total of 6 months.</p> <p>5) Date of compliance: 1/30/15</p> <p>Extinguisher Check</p> <p>Date</p> <p>Location</p> <p>Pass Y/N</p> <p>Date</p> <p>Location</p> <p>Pass Y/N</p>		

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K010068 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Combustion and ventilation air for boiler, incinerator and heater rooms is taken from and discharged to the outside air. 19.5.2.2			

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	<p>Based on observation and interview, the facility failed to ensure makeup combustion air from the outside was provided for 2 of 4 rooms containing fuel fired equipment. NFPA 54, 1999 Edition of the National Fuel Gas Code , Section 6.4.3(b) requires for the provision for makeup air for Type 2 clothes dryers. A Type 2 clothes dryer is defined as "not designed for use in an individual family living environment." This deficient practice could affect visitors, staff, and any resident in the smoke compartment adjacent to the laundry and mechanical room located on the lower level of the Pines.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director on 01/07/15 at between 11:15 a.m. and 1:30 p.m., the laundry room had three, gas fueled dryers with no fresh air intake. The Maintenance Director said at the time of observation, ceiling vents in the room were not providing fresh air. In addition, the mechanical room near there maintenance shop housed a gas fueled service water heater. A strong odor of the gas was apparent upon opening the door and entering the room. The Maintenance Director acknowledged the fresh air intake for the room was</p>	K010068	<p>K 068</p> <p>The facility requestspaper compliance for this citation.</p> <p><i>This Plan of Correction isthe center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correctiondoes not constitute admission or agreement by the provider of the truth of thefacts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/orexecuted solely because it is required by the provisions of federal and statelaw.</i></p> <p>1) Immediate actiontaken for areas identified: Vendor called in to assess rooms for properventilation.</p> <p>2) How the facilityidentified other rooms: All rooms containing fuel fired equipment assessed forproper air exchange by vendor.</p> <p>3) Measures put intoplace/ System changes: Laundry room determined to have proper and adequateexisting ventilation, the ducting for this ventilation was shown to theDirector of</p>	01/30/2015

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	insufficient. He said he was getting quotes to resolve the issue. 3.1-19(b)		<p>Maintenance. *See attached photo. Boiler room fire safe ventinstalled in door to allow for fresh air intake. *See attached photo. Audittool put in place to assess rooms with fuel fired equipment for strong fuelodors. *See attached audit tool.</p> <p>4) How the corrective actions will be monitored:</p> <p>The results of these auditswill be reviewed in Quality Assurance Meeting monthly x3 months, then quarterlyx1 for a total of 6 months.</p> <p>5) Date ofcompliance: 1/30/15</p> <p>Fuel Fired EquipmentRoom Audit</p> <p>Date</p> <p>Location</p> <p>Pass Y/N</p> <p>Date</p> <p>Location</p>		

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K010144 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and			

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	<p>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 ensure 1 of 2 emergency generators was provided with an alarm annunciator in a location readily observed by operating personnel at a regular work station such as a nurses' station. NFPA 99, Health Care Facilities, 3-4.1.1.15 requires a remote annunciator, storage battery powered, shall be provided to operate outside of the generating room in a location readily observed by operating personnel at a regular work station. The annunciator shall indicate alarm conditions of the emergency or auxiliary power source as follows:</p> <p>(a) Individual visual signals shall indicate:</p> <ol style="list-style-type: none"> 1. When the emergency or auxiliary power source is operating to supply power to load. 2. When the battery charger is malfunctioning. <p>(b) Individual visual signals plus a common audible signal to warn of an engine generator alarm condition shall indicate:</p> <ol style="list-style-type: none"> 1. Low lubricating oil pressure. 2. Low water temperature. 3. Excessive water temperature. 4. Low fuel - when the main fuel storage tank contains less than a 3 hour operating 	K010144	<p>K144</p> <p>The facility requests paper compliance for this citation.</p> <p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>1) Immediate action taken for those annunciators identified: Vendor called in to provide solution quote.</p> <p>2) How the facility identified other equipment: Other annunciator in satisfactory location.</p> <p>3) Measures put into place/ System changes: Additional annunciator to be installed near Pines North nurses station. Annunciator function will be checked during</p>	01/30/2015

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	<p>supply.</p> <p>5. Overcrank (failed to start).</p> <p>6. Overspeed.</p> <p>Where a regular work station will be unattended periodically, an audible and visual derangement signal, appropriately labeled, shall be established at a continuously monitored location. This derangement signal shall activate when any of the conditions in 3-4.1.1.15(a) and (b) occur but need not display these conditions individually. This deficient practice could affect visitors, staff and 30 or more residents in the Pines building.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director on 01/07/15 at 1:50 p.m., a remote alarm annunciator for the Pines generator was located at the lower level Pines nurses station which, along with the unit was unoccupied. The Maintenance Director acknowledged at the time of observation, the remote alarm annunciator for the generator was not in a location readily observed by operating personnel at a regular work station such as a nurses' station.</p> <p>3.1-19(b)</p>		<p>generator tests.*See attached audit tool.</p> <p>4) How the corrective actions will be monitored:</p> <p>The results of these audits will be reviewed in Quality Assurance Meeting monthly x3 months, then quarterly x1 for a total of 6 months.</p> <p>5) Date of compliance: 1/30/15 Annunciator Check</p> <p>Date</p> <p>Location</p> <p>Pass Y/N</p> <p>Date</p> <p>Location</p> <p>Pass Y/N</p>				

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K010147 SS=E	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 11 of 11 flexible cords were not used as a substitute for	K010147	K 147 The facility requestpaper compliance for this citation.	01/30/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155277	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 01/07/2015
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NAME OF PROVIDER OR SUPPLIER APERION CARE VALPARAISO	STREET ADDRESS, CITY, STATE, ZIP CODE 3301 N CALUMET AVE VALPARAISO, IN 46383
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	<p>fixed wiring. NFPA 70 National Electrical Code, 1999 Edition, Article 400-8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect visitors, staff and 10 or more residents on the upper level of Pines and lower level of the Manor building.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director on 01/07/15 between 11:15 a.m. and 2:45 p.m., power strip extension cords were:</p> <ul style="list-style-type: none"> a. Used to power two coffee pots, a microwave and a refrigerator in the business office; b. Located under the head of the resident's bed in room 157 to power a charger. An extension cord was also in use to power other equipment in the room; c. Located under the head of the bead in room 18 to power the electric bed. An extension cord provided power for an oxygen concentrator in room; d. Located under the resident bed in room 20 to provide power to an oxygen concentrator. e. An extension cord was used to power equipment in resident room 6. 		<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>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 statelaw.</i></p> <p>1) Immediate action taken for those issues identified: Identified power cords removed.</p> <p>2) How the facility identified other flexible power cords: Facility wide sweep scheduled to be completed by 1/30/15. Vendor called in to provide quotes for installation of additional outlets where necessary.</p> <p>3) Measures put into place/ System changes: Monthly rounds to be performed by Director of Maintenance or designee to look for presence of flexible power cords. *See attached audit tool. Findings will be provided to the Administrator.</p>	

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	<p>f. A power strip extension cord was located under the head of the resident be in room 16 to power equipment in the room.</p> <p>g. A power strip was used in resident room 19 to provide power to an oxygen concentrator and a nebulizer.</p> <p>h. In resident room 4 an IV pump and refrigerator was powered by two power strip extension cords located under and beside the resident bed.</p> <p>i. An extension cord provided power to a light fixture in the Linden dining room. The maintenance director acknowledged at the time of observation, the use of the flexible cords to power medical and other equipment.</p> <p>3.1-19(b)</p>		<p>4) How the corrective actions will be monitored:</p> <p>The results of these audits will be reviewed in Quality Assurance Meeting monthly x3 months, then quarterly x1 for a total of 6 months.</p> <p>5) Date of compliance: 1/30/15</p> <p>Power Cord Audit</p> <p>Date</p> <p>Location</p> <p>Present Y/N</p> <p>Date</p> <p>Location</p> <p>Present Y/N</p>	
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO. 0938-0391

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