

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  03/17/2016
--	---	--	---

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 0000  Bldg. 01	<p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 03/17/16</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 II (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors and hard wired detectors in all resident sleeping rooms. The facility has a capacity of 93 and had a census of 75 at the time of this survey.</p>	K 0000		

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

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

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  03/17/2016
--	---	--	---

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 0025 SS=E Bldg. 01	<p>All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered except for one detached generator shed which provided facility storage and was not sprinklered.</p> <p>Quality Review completed on 03/24/16 - DA</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers shall be constructed to provide at least a one half hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels and steel frames. 8.3, 19.3.7.3, 19.3.7.5</p> <p>Based on observation and interview, the facility failed to ensure 1 of 5 smoke barriers was protected to maintain the one half hour fire resistance rating of the smoke barrier. LSC Section 8.3.6.1 requires the passage of building service materials such as pipe, cable or wire be protected, so the space between the penetrating item and the smoke barrier shall be filled with a material capable of maintaining the smoke resistance of the smoke barrier or be protected by an approved device designed for the specific purpose. This deficient practice could</p>	K 0025	<p><b><u>APERION CARE DEMOTTE PLAN OF CORECTION K -025</u></b></p> <p>Please accept this Plan of Correction as the facility's credible allegation of compliance. Submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by the State and Federal regulations. 1. Corrective Actions taken and /or how the deficiency will be corrected : The smoke barrier wall opening located next to the Nursing Station has been filled with a fire</p>	04/08/2016

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  03/17/2016
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 0029 SS=E Bldg. 01	<p>affect 24 residents on unit 7 hall if smoke from a fire were to infiltrate the protective barrier.</p> <p>Findings include:</p> <p>Based on observation on 03/17/16 at 2:30 p.m. with the Maintenance Supervisor, the smoke barrier located next to the Nursing station on unit 7 hall had an exposed opening the size of a golf ball at the lower left side of the wall which was not firestopped. Based on interview on 03/17/16 at 2:34 p.m. with the Maintenance Supervisor, it was acknowledged the aforementioned smoke barrier wall had an opening which was not filled with a fire rated material to maintain a one half hour fire resistance rating.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with o hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with</p>		<p>material to maintain a one half hour fire resistance rating . 2. Actions the facility will take to ensure that no other examples of the deficiency exists in other parts of the building : The Maintenance Director has examined all areas of the building throughout the facility to ensure that no other deficiency exists in other parts of the building. The Maintenance Director will instruct and follow-up with outside vendors to ensure penetrations are sealed upon completion of work . 3. Measures put into place or systemic changes made to ensure that the deficient practice will not recur : To ensure ongoing compliance, monthly inspections will be conducted by the Maintenance Director /Designee times three months to ensure that all penetrations are sealed. 4. Quality Assurance Plans to monitor performance and ensure that solutions are sustained : Monthly Audits times three months of QA tools will be conducted by the HFA/Designee to ensure compliance. System performance will be reviewed at the monthly QA meeting until resolution is achieved. Completion Date 4/8/2016</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  03/17/2016
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>8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>Based on observation and interview, the facility failed to ensure 2 of 2 doors leading to hazardous areas such as the Kitchen would have doors with a latching device. This deficiency could affect 28 residents on unit 5 hall which is adjacent to Main hall as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observation on 03/17/16 at 1:35 p.m. with the Maintenance Supervisor, the two kitchen doors leading into the Main dining room on Main hall were not provided with latching devices to keep the doors latched securing in their frames. Based on interview on 03/17/16 concurrent with the observation with the Maintenance Supervisor it was acknowledged the aforementioned hazardous area was not provided with doors which have latching devices to keep the doors latched into their frames.</p> <p>3.1-19(b)</p>	K 0029	<p><b><u>APERION CARE DEMOTTE PLAN OF CORECTION K -029</u></b></p> <p>Please accept this Plan of Correction as the facility's credible allegation of compliance. Submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by the State and Federal regulations. 1. Corrective Actions taken and /or how the deficiency will be corrected : Sliding locks removed from kitchen doors and replaced with door knobs with locks. 2. Actions the facility will take to ensure that no other examples of the deficiency exists in other parts of the building : The Maintenance Director has examined all areas of the building throughout the facility to ensure that no other deficiency exists in other parts of the building. 3. Measures put into place or systemic changes made to ensure that the deficient practice will not recur : To ensure ongoing compliance, monthly inspections will be conducted by</p>	04/08/2016	

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  03/17/2016
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 0050 SS=F Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM a coded announcement may be used instead of audible alarms. 18.7.1.2, 19.7.1.2</p> <p>Based on record review and interview, the facility failed to ensure fire drills included the verification of transmission of the fire alarm signal to the monitoring station in fire drills conducted between 6:00 a.m. and 9:00 p.m. for the last 4 of 4 quarters. LSC 19.7.1.2 requires fire exit drills in health care occupancies shall</p>	K 0050	<p>the Maintenance Director /Designee times three months to ensure that no slide locks exist in the facility. 4. Quality Assurance Plans to monitor performance and ensure that solutions are sustained : Monthly Audits times three months of QA tools will be conducted by the HFA/Designee to ensure compliance. System performance will be reviewed at the monthly QA meeting until resolution is achieved. Completion Date 4/8/2016</p> <p><b><u>APERION CARE DEMOTTE</u></b></p> <p><b><u>PLAN OF CORECTION K -050</u></b></p> <p>Please accept this Plan of Correction as the facility's credible allegation of compliance. Submission of this Plan of Correction is not an admission that a deficiency exists or that one</p>	04/08/2016	

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  03/17/2016
--	---	---	---

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>include the transmission of a fire alarm signal and simulation of emergency fire conditions. This deficient practice affects all residents in the facility as well as staff and visitors.</p> <p>Findings include:</p> <p>Based on review of Fire Drill Reports on 03/17/16 at 4:04 p.m. with the Maintenance Supervisor, the documentation for the drills performed between the hours of 6:00 a.m. and 9:00 p.m. for the past twelve months, from 02/2016 to 02/2015 indicated verification of the transmission of the signal was not documented. Based on interview concurrent with record review it was acknowledged the documentation of the transmission of the signal was not recorded.</p> <p>3.1-19(b) 3.1-51(c)</p>		<p>was cited correctly. This Plan of Correction is submitted to meet requirements established by the State and Federal regulations.</p> <p>1. Corrective Actions taken and /or how the deficiency will be corrected :</p> <p>Maintenance Director In-Serviced regarding proper documentation regarding Fire Drills. The monitoring station 'Safe Care' contacted for verification of signal when Fire Drills were held. Monthly Fire and Evacuation Alarm/Drill Report now reflects verification of transmission of the fire alarm signal to the monitoring station 'Safe Care.'</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 areas of the building throughout the facility to ensure that no other deficiency exists in other parts of the building.</p> <p>3. Measures put into place or systemic changes made to ensure that the deficient practice will not</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  03/17/2016
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 0062 SS=B Bldg. 01	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  1. Based on observation and interview, the facility failed to provide a complete supply of spare sprinklers in 1 of 1 riser rooms in accordance with NFPA 25, 1998 Edition, the Standard for the	K 0062	recur :  To ensure ongoing compliance, monthly inspections will be conducted by the HFA/Designee times three months to ensure that documentation regarding fire alarm signal transmission and verification occurred.  4. Quality Assurance Plans to monitor performance and ensure that solutions are sustained :  Monthly Audits times three months of QA tools will be conducted by the HFA/Designee to ensure compliance. System performance will be reviewed at the monthly QA meeting until resolution is achieved.  Completion Date 4/8/2016  <b><u>APERION CARE DEMOTTE PLAN OF CORECTION K -062</u></b> Please accept this Plan of Correction as the facility's credible allegation of compliance. Submission of this Plan of	04/08/2016	

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  03/17/2016	
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>Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, Section 2-4.1.4 which requires supply of at least six spare sprinklers shall be stored in a cabinet on the premises for replacement purposes. The stock of spare sprinklers shall be proportionally representative of the types and temperature ratings of the system sprinklers. A minimum of two sprinklers of each type and temperature rating installed shall be provided. This deficient practice could affect all residents throughout the facility as well as staff and visitors if the sprinkler system had to be shut down because a proper sprinkler head wasn't available as a replacement.</p> <p>Findings include:</p> <p>Based on observation on 03/17/16 at 2:05 p.m. with the Maintenance Supervisor, the Riser room in the Mechanical room on Main hall which contained the sprinkler box with extra sprinkler heads was not equipped with side mount sprinkler heads which were observed being used in the Therapy exit on unit 2 hall. Based on interview on 03/17/16 at 2:06 p.m. with the Maintenance Supervisor it was acknowledged the spare sprinkler cabinet located in the Riser room did not have two of each type</p>		<p>Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by the State and Federal regulations. 1. Corrective Actions taken and /or how the deficiency will be corrected : Safe Care notified and six sprinkler heads were sent to the facility and placed in the spare sprinkler cabinet on premises for replacement purposes on 3/28/16. Seven sprinkler heads were cleaned in the kitchen on 3/17/16. Maintenance Director checked all sprinkler heads in facility to ensure compliance . 2. Actions the facility will take to ensure that no other examples of the deficiency exists in other parts of the building : Maintenance Director will clean sprinkler heads weekly with filter changes and ensure documentation is present and sprinkler heads are free of debris. 3. Measures put into place or systemic changes made to ensure that the deficient practice will not recur : To ensure ongoing compliance, weekly inspections will be conducted by the Maintenance Director/Designee times three months to ensure that all sprinkler heads throughout the facility are free of debris. 4. Quality Assurance Plans to monitor performance and ensure that solutions are sustained : Monthly</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  03/17/2016
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 0070 SS=E Bldg. 01	<p>of sprinkler heads in the sprinkler box.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 7 of 11 sprinkler heads in the Kitchen were not loaded with grease, dust or corrosion. NFPA 25, 1998 edition, 2-2.1.1 requires any sprinkler shall be replaced which is painted, corroded, damaged, loaded, or in the improper orientation. This deficient practice could affect the 12 residents on West hall which is adjacent to the Kitchen as well as staff and visitors.</p> <p>Findings include:</p> <p>Based on observation on 01/19/16 at 2:30 p.m. with the Maintenance Supervisor, the sprinkler heads located in the Kitchen around the cooking area were heavily coated with grease, dust and corrosion. Based on interview on 01/19/16 at 2:31 p.m. with the Maintenance Supervisor it was confirmed the sprinkler heads in aforementioned location were loaded as described.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Portable space heating devices shall be prohibited in all health care occupancies.</p>		<p>Audits times three months of QA tools will be conducted by the HFA/Designee to ensure compliance. System performance will be reviewed at the monthly QA meeting until resolution is achieved. Completion Date 4/8/2016</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  03/17/2016
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>Except it shall be permitted to be used in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212 degrees F (100 degrees C). 18.7.8, 19.7.8</p> <p>Based on observation, interview and record review, the facility failed to regulate the use of 1 of 1 portable space heaters observed in nonresident rooms. This deficient practice could affect any resident on unit 5 hall as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observation on 03/17/16 at 1:25 p.m. with the Maintenance Supervisor, one portable space heater was not plugged in, but readily available for use in the Admissions office on unit 5 hall. Based on interview on 03/17/16 concurrent with the observation, it was acknowledged by the Admissions staff was available for use and no documentation pertaining to the portable space heater was available for review.</p> <p>3.1-19(b)</p>	K 0070	<p><u>CAAPERION CARE DEMOTTE</u></p> <p><u>PLAN OF CORECTION K -070</u></p> <p>Please accept this Plan of Correction as the facility's credible allegation of compliance. Submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by the State and Federal regulations.</p> <p>1. Corrective Actions taken and /or how the deficiency will be corrected :</p> <p>Portable space heater removed from Admission office on 3/17/16.</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 offices throughout the facility to ensure that no other examples of this</p>	04/08/2016	

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  03/17/2016
--	---	--	---

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 0147 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment shall be in accordance with National Electrical Code. 9-1.2 (NFPA 99) 18.9.1, 19.9.1		<p>deficiency exists in other parts of the building.</p> <p>3. Measures put into place or systemic changes made to ensure that the deficient practice will not recur :</p> <p>To ensure on-going compliance, weekly inspections will be conducted by the Maintenance Director /Designee times three months to ensure that all areas of the building are free of space heaters .</p> <p>4. Quality Assurance Plans to monitor performance and ensure that solutions are sustained :</p> <p>Monthly Audits times three months of QA tools will be conducted by the HFA/Designee to ensure compliance. System performance will be reviewed//d at the monthly QA meeting until resolution is achieved.</p> <p>Completion Date 4/8/2016</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  03/17/2016
--	---	---	---

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>1. Based on observation and interview, the facility failed to ensure 2 of 2 non-fused multiplug adapters observed were not used as a substitute for fixed wiring. LSC 19.5.1 requires utilities to comply with Section 9.1. LSC 9.1.1 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 1999 Edition. NFPA 70, Article 400-8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice would affect 28 residents on unit 5 hall as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observations on 03/17/16 during the tour from 1:00 pm. to 2:00 p.m. with the Maintenance Supervisor, the following was noted:</p> <p>a) A non-fused multiplug was used to power computer equipment in the Medical records office and the Director of Nursing office on unit 5 hall.</p> <p>Based on interview with the Maintenance Supervisor at the time of observations during the tour non-fused multiplug adapters were used in the aforementioned staff offices.</p> <p>3.1-19(b)</p>	K 0147	<p><b><u>APERION CARE DEMOTTE</u></b></p> <p><b><u>PLAN OF CORECTION K -147</u></b></p> <p>Please accept this Plan of Correction as the facility's credible allegation of compliance. Submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by the State and Federal regulations.</p> <p>1. Corrective Actions taken and /or how the deficiency will be corrected :</p> <p>All multi-plugs in offices were removed on 3/17/16 and replaced with power strips.</p> <p>Maintenance Director examined all ceiling Junction Boxes and added Box Extenders with covers.</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 offices throughout the building to ensure that no other examples of the deficiency exist in</p>	04/08/2016

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  03/17/2016
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. Based on observation and interview, the facility failed to ensure 6 of 6 electrical wires observed above the ceiling at the smoke wall next to the nursing station on unit 7 hall were confined in an electrical junction box with a cover. NFPA 70, National Electrical Code, 1999 Edition, 1999 Edition, Article 370-28(c) requires exposed electrical wires be confined within a junction box with a cover compatible with the box. This deficient practice could affect 24 residents on unit 7 hall as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observation on 03/17/16 at 3:31 p.m. with the Maintenance Supervisor, a total of six electrical wires were exposed above the ceiling at the unit 7 hall smoke wall next to the nursing station. The electrical wires were sticking out of the junction box without a cover to confine the wires within the box. Based on interview on 03/17/16 concurrent with the observation it was acknowledged by the Maintenance Supervisor, the electrical wires described were exposed and not protected within a junction box with a cover.</p> <p>3.1-19(b)</p>		<p>other parts of the building.</p> <p>3. Measures put into place or systemic changes made to ensure that the deficient practice will not recur :</p> <p>To ensure on-going compliance, monthly inspections will be conducted by the Maintenance Director /Designee times three months to ensure that all offices are free of multi-plugs and that all Junction Boxes will have added Box Extenders with covers .</p> <p>4. Quality Assurance Plans to monitor performance and ensure that solutions are sustained :</p> <p>Monthly Audits times three months of QA tools will be conducted by the HFA/Designee to ensure compliance. System performance will be reviewed//d at the monthly QA meeting until resolution is achieved.</p> <p>Completion Date 4/8/2016</p>		

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

PRINTED: 04/08/2016

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 <u>01</u> B. WING _____		X3) DATE SURVEY COMPLETED 03/17/2016
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	