

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155580	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 02/26/2015
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NAME OF PROVIDER OR SUPPLIER APERION CARE TOLLESTON PARK	STREET ADDRESS, CITY, STATE, ZIP CODE 2350 TAFT ST GARY, IN 46404
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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: 02/26/15</p> <p>Facility Number: 008505 Provider Number: 155580 AIM Number: 200064830</p> <p>Surveyor: Bridget Brown, Life Safety Code Specialist</p> <p>At this life Safety Code survey, Aperion Care Tolleston Park 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 with a partial basement was determined to be of Type V (111) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors.</p>	K 000		
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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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K 017 SS=E Bldg. 01	<p>Battery powered smoke detectors are located in the North and South wing resident rooms; the PCU resident rooms are equipped with hard wired smoke detectors. The facility has the capacity for 180 and had a census of 114 at the time of this survey.</p> <p>All areas where the residents have customary access were sprinklered. A detached wood equipment storage shed was unsprinklered.</p> <p>Quality Review by Dennis Austill, Life Safety Code Specialist on 03/02/15.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Corridors are separated from use areas by walls constructed with at least ½ hour fire resistance rating. In sprinklered buildings, partitions are only required to resist the passage of smoke. In non-sprinklered buildings, walls properly extend above the ceiling. (Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Charting and clerical stations, waiting areas, dining rooms, and activity spaces may be open to the corridor under certain conditions specified in the</p>						

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	<p>Code. Gift shops may be separated from corridors by non-fire rated walls if the gift shop is fully sprinklered.) 19.3.6.1, 19.3.6.2.1, 19.3.6.5</p> <p>Based on observation and interview, the facility failed to ensure 1 of 2 open use areas was separated from the corridors by a partition capable of resisting the passage of smoke as required in a sprinklered building, or met an Exception. LSC 19-3.6.1, Exception # 6, Spaces other than patient sleeping rooms, treatment rooms, and hazardous areas may be open to the corridor and unlimited in area provided: (a) The space and corridors which the space opens onto in the same smoke compartment are protected by an electrically supervised automatic smoke detection system, and (b) Each space is protected by automatic sprinklers, and (c) The space is arranged not to obstruct access to required exits. This deficient practice could affect any visitors, staff and any resident using the employee exit.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director on 02/26/15 at 12:50 p.m., the employee break room was open to the corridor. The space was protected by a battery powered smoke detector. The Maintenance Director acknowledged the smoke detector did not</p>	K 017	<p>K017 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 residents identified: Electrician was notified and scheduled installation of an electronically supervised smoke detection system in the employee break room. 2) How the facility identified other residents: All other open use areas were checked to ensure electronically supervised smoke detection systems were installed. No other issues were identified. 3) Measures put into place/ System changes: Maintenance department will check all smoke detectors at least monthly to ensure proper functioning and compliance. Executive</p>	03/25/2015			

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K 038 SS=E Bldg. 01	<p>meet the requirement for electronically supervised smoke detection.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p> <p>Based on observation and interview, the facility failed to ensure 4 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 evacuating the 200 hall, PCU unit and the PCU and main dining rooms.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director on 02/26/15 between 12:00 p.m. and 2:30 p.m., the exit discharge surfaces for the main dining room, PCU dining room and those near room 206 and 304 were snow covered. The Maintenance Director said</p>	K 038	<p>Director will be responsible for oversight. 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: 3/25/15</p> <p>K038 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 residents identified: Exits and means of egress for areas identified were cleaned free of snow and ice. 2) How the facility identified other residents: All exits and means of egress were checked and were cleaned free of snow</p>	03/25/2015	

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K 044 SS=E Bldg. 01	<p>acknowledged at the time of observation, the snow covered surfaces were not safely accessible and visible to any evacuation point.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Horizontal exits, if used, are in accordance with 7.2.4. 19.2.2.5</p> <p>Based on observation and interview, the facility failed to ensure 1 of 3 fire door sets was arranged to automatically close and latch. LSC 7.2.4.3.8 requires fire barrier doors to be self closing or automatic closing in accordance with 7.2.1.8. NFPA 80, the Standard for fire Doors and Fire Windows at 2-4.1.4 requires all closing mechanisms shall be adjusted to overcome the resistance of the latch mechanism so positive latching is achieved on each door operation. This</p>	K 044	<p>and ice as identified. 3) Measures put into place/ System changes: Maintenance personnel or designee will be assigned an on-call schedule to remove snow and ice from exits and means of egress following significant snowfall with accumulation. The Executive Director or designee will monitor to ensure compliance. 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: 3/25/15</p> <p>K044 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</p>	03/25/2015	

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K 056 SS=E Bldg. 01	<p>deficient practice affects visitors, staff, and 10 or more residents on PCU.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director on 02/26/15 at 1:40 p.m., the fire door set near room 312 was tested twice manually. One door in the fire door set failed to latch each time the doors were released to close. The door failed to latch again at 1:45 p.m. when the fire alarm was activated. The Maintenance Director agreed, at the times of observation, there was a problem with the latching mechanism.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate</p>		<p><i>federal and state law.</i> 1) Immediate action taken for those residents identified: Vendor was notified and latching mechanism was repaired to automatically close and latch. 2) How the facility identified other residents: All fire doors were checked to ensure latching mechanisms were functioning properly to automatically close and latch. 3) Measures put into place/ System changes: Maintenance Director designee will check fire doors weekly to ensure doors properly close and latch automatically. 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: 3/25/15</p>	

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	<p>water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5</p> <p>Based on record review, observation and interview; the facility failed to ensure 4 of 5 resident shower stalls in the North wing shower room were provided with an automatic sprinkler system to ensure sprinkler coverage in all portions of the building. This deficient practice could affect staff or 10 or more residents on the North wing.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director on 02/26/15 at 1:05 p.m., sprinkler coverage was not provided in four shower stalls in the North wing shower room. The Maintenance Director acknowledged at the time of observations, other sprinklers in the shower room could not protect the aforementioned shower stalls.</p> <p>3.1-19(b)</p>	K 056	<p>K056 The facility requestspaper compliance for this citation. This Plan of Correction isthe center's credible allegation of compliance. 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 state law. 1) Immediate actionstaken for those residents identified: Vendor was notifiedand completed installation of automatic sprinkler system in the North wingshower room. 2) How the facilityidentified other residents: All residents onNorth unit have the potential to be affected. No other concerns were identified. 3) Measures put into place/ System changes: MaintenanceSupervisor or designee will check sprinklers at least monthly to ensurecompliance. 4) How the corrective actions will be monitored: The results of theseaudits will be reviewed in</p>	03/25/2015

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

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