STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155702	A. BUILDING 01 B. WING	10/29/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE PERU	1850 WEST MATADOR ST PERU, IN 46970

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 10/29/15 Facility Number: 003130 Provider Number: 155702 AIM Number: 200386750 At this Life Safety Code survey, Aperion Care-Peru was not found in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR 483.70(a), Life Safety from Fire, the 2000 edition of the NFPA (National Fire Protection Association) 101, LSC (Life Safety Code), and 410 IAC 16.2. The original building consists of everything except the West Wing and was surveyed with Chapter 19, Existing Health Care Occupancies. This one story facility was determined to be of Type II (222) 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 smoke detectors in all resident rooms. The facility has a	K 0000	*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.*	

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

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	capacity of 92 and had a census of 54 at the time of this survey. All areas where the residents have customary access were sprinklered with exception of two window recesses in the therapy room. All areas providing facility services were sprinklered. Quality Review completed 11/12/15 - DA			
K 0018 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. 1. Based on observation and interview, the facility failed to ensure there were no impediments to the closing of 1 of 58 resident room doors of the facility protecting corridor openings. This deficient practice could affect up to 35 residents in the main hall.	K 0018	All rubber stoppers removed from facility on 10/30/2015. No rubber stoppers or unapproved devices to be used to prop ajar doors. Additionally, double doors cited were adjusted to ensure proper closure on 100/30/2015.	11/28/2015

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	Findings include: Based on observation during a tour of the facility with the Maintenance Director on 10/29/15 at 12:45 p.m., the corridor door to resident room 137 was obstructed from closing by a rubber stopper wedged under the door. Based on interview at the time of observation, this was acknowledged by the Maintenance Director. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 58 resident room doors closed and latched into the door frame. This deficient practice could affect up to 35 residents in the main hall. Findings include: Based on observation during a tour of the facility with the Maintenance Director on 10/29/15 at 12:50 p.m., the corridor door to resident room 125 was equipped with a double door system where the first door automatically latched into the frame and the second door latched into the first door, but the first door failed to latch into the door frame. Based on interview at the time of observation, this was acknowledged by the Maintenance Director.		Facility audit performed to ensure no other devices were being used to prop open doors. Facility will also perform monthly audit on double doors to ensure proper closure and latches work properly. Maintenance or designee will perform monthly audit to ensure that no unapproved devices are being used to prop ajar doors in the facility. In addition, all double doors will be checked to ensure the properly close and latch as intended on a monthly basis. Findings will be given to the QA Committee monthly for a period of 6 months or until a pattern of substantial compliance is achieved.	

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	3.1-19(b)			
K 0021 SS=E Bldg. 01	NFPA 101 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: a) the required manual fire alarm system; b) local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and c) the automatic sprinkler system, if installed. 19.2.2.2.6, 7.2.1.8.2 Based on observation and interview, the facility failed to ensure 1 of 2 kitchen doors to the dining room were held open only by a device which would allow it to close automatically upon activation of the fire alarm system. This deficient practice could affect up to 40 residents in the main dining room. Findings include: Based on observation during a tour of the facility with the Maintenance Director on 10/29/15 at 11:07 a.m., the left dining room door leading into the kitchen was held open with a rubber stop. Based on interview, this was acknowledged by the	K 0021	All rubber stoppers removed from facility on 10/30/2015. No rubber stoppers or unapproved devices to be used to prop ajar doors. Facility audit performed to ensure no other devices were being used to prop open doors. Maintenance or designee will perform monthly audit to ensure that no unapproved devices are being used to prop ajar doors in the facility. Findings will be given to the QA Committee monthly for a period of 6 months or until a pattern of substantial compliance is achieved.	11/28/2015

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	Maintenance Director at the time of observation. 3.1-19(b)			
K 0025 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD 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 1. Based on observation and interview, the facility failed to ensure the penetrations caused by the passage of wire and/or conduit through 3 of 7 smoke barrier walls were protected to maintain the smoke resistance of each smoke barrier. LSC Section 19.3.7.3 requires smoke barriers to be constructed in accordance with LSC Section 8-3. 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	K 0025	The smoke barrier penetrations cited will be repaired with approved material capable of maintaining the smoke resistance to that smoke barrier. The opening in the closet on Touchstone will be patched and repaired according to Life Safety standards. Areas in question to be repaired on November 27, 2015. Facility to audit all smoke barrier walls to ensure no penetrations or unapproved material is being used to prevent smoke transfer. Any openings or areas with unapproved material will be patched and repaired appropriately. Maintenance or designee shall	11/28/2015

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	designed for the specific purpose. This deficient practice could affect 40 residents in 4 of 8 smoke compartments. Findings include: Based on observation during a tour of the facility with the Maintenance Director on 10/29/15 between 1:00 p.m. and 2:20 p.m., the following smoke barrier walls had unsealed penetrations or penetrations filled with an un-approved material: a) above the ceiling tiles of the "T" hall smoke barrier wall there were two penetrations filled with drywall mud and black caulk around pipes. b) above the ceiling tiles of the smoke barrier wall by room 129 there was a pipe sleeve filled with yellow caulk. Based on interview at the time of observation, the Maintenance Director did not know if the yellow or black caulk was an approved material and did not have the documentation to show if the caulk met the requirements for use in through penetration fire stop systems. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 1 ceiling smoke barriers were maintained to provide a one half hour fire resistance rating. LSC 8.3.2 requires smoke barriers		perform monthly audit to ensure all smoke barriers are intact and proper material is used for penetrations. Findings will be given to the QA Committee monthly for a period of 6 months or until a pattern of substantial compliance is achieved.	

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	shall be continuous from an outside wall to an outside wall. This deficient practice could affect 28 residents in 2 of 6 smoke compartments. Based on observation during a tour of the facility with the Maintenance Director on 10/29/15 between 10:00 a.m. and 11:30 a.m., in the ceiling of the main hall medication room there were two penetrations sealed with white caulk. Also in the ceiling of the Touchstone housekeeping closet there was a two foot by two foot hole. Based on interview at the time of observation, the Maintenance Director provided the measurement of the hole, and did not know if the white caulk was an approved material and did not have the documentation to show if the caulk met the requirements for use in through penetration fire stop systems. 3.1-19(b)			
K 0029 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 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			

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	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 Based on observation and interview, the facility failed to ensure 1 of 2 dining room doors to the kitchen automatically close and latch into the door frame. This deficient practice could affect up to 40 residents using the dining room. Findings include: Based on observation during a tour of the facility with the Maintenance Director on 10/29/15 at 11:07 a.m., the left dining room door leading into the kitchen was equipped with a self closing device but failed to latch into the frame. Based on Interview, this was acknowledged by the Maintenance Director at the time of observation. 3.1-19(b)	K 0029	The dining room door cited was adjusted and repaired on 10/30/2015 to ensure compliance. All self-closing doors will be audited by maintenance department to ensure that they close and latch properly on 11/27/2015. Monthly audit to be performed by maintenance or designee to ensure all self-closing doors in the facility close and latch appropriately. Findings will be given to the QA Committee monthly for a period of 6 months or until a pattern of substantial compliance is achieved.	11/28/2015
K 0038 SS=E Bldg. 01	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 1. Based on observation and interview, the facility failed to ensure the means of egress through 8 of 9 exits were readily	K 0038	The key codes to the exit doors were changed to match the mounted stickers 10/30/2015. Wooden board blocking door was	11/28/2015

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	accessible for residents without a clinical diagnosis requiring specialized security measures. LSC 18.2.2.2.4 requires doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side. Exception No. 1 requires door-locking arrangements without delayed egress shall be permitted in health care occupancies, or portions of health care occupancies, where the clinical needs of the residents require specialized security measures for their safety, provided staff can readily unlock such doors at all times. This deficient practice could affect 40 residents who did not require special security measures. Findings include: Based on observation during a tour of the facility with the Maintenance Director on 10/29/15 between 10:30 a.m. and 2:00 p.m., all of the facility exit doors, that did not require special security measures, were magnetically locked and could be opened by entering a code. The posted code on the keypad was "fiftysevenelevenstar" for all exits. When that code was inputted on the key pad, the door did not release. Based on interview at the time of observations, the Maintenance Director stated the code on the door has been changed and the code		removed on 10/30/2015. All additional exit doors with key codes were checked by maintenance to ensure code mounted matched the actual code. All other exit doors checked by maintenance to ensure nothing was obstructing their egress. Key codes will be changed on the first of every month to match the month and year (4 digits). Maintenance will perform a monthly audit to ensure compliance with key code and mounted pass code changes. Maintenance to also perform monthly an audit of all exit doors for obstructions to allow proper egress. Findings will be given to the QA Committee monthly for a period of 6 months or until a pattern of substantial compliance is achieved.	

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	posted on the key pad is an older code no longer working. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 9 exit discharge paths was readily accessible at all times. This deficient was not in a treatment area but could affect staff in the service hall. Findings include: Based on observation during a tour of the facility with the Maintenance Director on 10/29/15 at 10:16 a.m., in the generator room located in the service hall there was an double door identified as an exit with a wooden 2 x 4 crossing both doors and two sliding latches that would latch in the floor and frame in addition to the automatic latching door knob. Based on interview at the time of observation, the Maintenance Director identified the door as an exit and acknowledged the extra latching on the door. 3.1-19(b)			
K 0045 SS=F Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Illumination of means of egress, including			

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	exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8 Based on interview and observation, it was determined that the facility failed to provide exterior emergency lighting for 9 of 9 exits. LSC Section 7.9.1.1 requires emergency lighting facilities for means of egress shall be provided for the exit access and exit discharge. This deficient practice could affect all occupants in the facility if the facility was required to evacuate in an emergency and the generator was providing electricity at that time. Findings include: Based on observation during a tour of the facility with the Maintenance Director on 10/29/15 between 10:00 a.m. and 2:00 p.m., it was unknown if the exterior lights for the exit discharge for all of the facility exits were connected to the generator. Based on interview at the time of observation, when asked if the exterior lights were powered by the generator during power loss; the Maintenance Director stated "probably not but I do not know for sure. I will have to check with the generator company to find out." 3.1-19(b)	K 0045	Exterior lights for exit discharge were found to be in compliance by SafeCare on 11/6/2015. No exterior lights for exit discharge were found to be non-compliant. Exterior lights for exit discharge to be checked monthly by maintenance to ensure they are functioning properly. Findings will be given to the QA Committee monthly for a period of 6 months or until a pattern of substantial compliance is achieved.	11/28/2015

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K 0046 SS=F Bldg. 01	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. 1. Based on observation, records and interview; the facility failed to ensure emergency light fixtures for 1 of 1 generators were tested annually for 1½ hour duration and monthly for 30 second duration in accordance with LSC 7.9. LSC 7.9.3 Periodic Testing of Emergency Lighting Equipment requires an annual test shall be conducted on every required battery powered emergency lighting system for a minimum of 1 ½ hour duration and every required battery powered emergency lighting system at 30 day intervals for a minimum of 30 seconds. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect all occupants. Findings include: Based on observation during a tour of the facility with the Maintenance Director on	K 0046	All emergency battery powered lights were tested for 90 minutes on 11/27/2015. Malfunctioning emergency battery powered light with no test button was replaced on 11/27/2015. All emergency battery powered lights in the facility will be tested monthly for 30 seconds and 90 minutes annually. Findings will be given to the QA Committee monthly for a period of 6 months or until a pattern of substantial compliance is achieved.	11/28/2015

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	10/29/15 at 10:30 a.m., a pair of lights powered by a battery as backup lighting for the emergency generator was observed by the generator. Based on records review with the Maintenance Director on 10/29/15 at 10:00 a.m., no documentation was available for review to show the testing of the emergency battery powered lights at the facility's generator. Based on interview at the time of record review and observation, when ask if the emergency battery powered lights are tested 30 seconds monthly and 90 minutes annually; the Maintenance Director stated the emergency battery powered lights are not tested for 30 seconds monthly or 90 minutes annually. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 1 battery powered emergency lighting fixtures at the generator would operate. LSC 7.9.2.5 requires battery operated emergency lights shall be capable of repeated automatic operation. This deficient practice could affect all occupants. Findings include: Based on observation during a tour of the facility with the Maintenance Director on 10/29/15 at 10:30 a.m., a pair of lights			

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	powered by a battery as backup lighting for the emergency generator was observed by the generator. The battery operated lights failed to illuminate because there was no test button to test the lights. Base on interview at the time of observation, the Maintenance Director tried to test the lights but could not find a way to test the lights. 3.1-19(b)			
K 0050 SS=F Bldg. 01	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 Based on record review and interview, the facility failed to ensure fire drills were conducted quarterly on each shift for 3 of the last 4 completed quarters. This deficient practice could affect all occupants. Findings include: Based on record review of the "Fire Drill Report" with the Maintenance Director	K 0050	Fire drills will begin to be performed and documented on a monthly basis by the facility maintenance department or designee. Fire Drills will consist of all three shifts per quarter being performed at random times throughout the year. Monthly fire drills will be sent to the QA Committee on a monthly basis indefinitely to ensure continued compliance.	11/28/2015

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(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
	on 10/29/15 at 10:10 a.m., there were no records of fire drills for the following quarters: a.) first quarter of 2015 for first, second, and third shifts. b.) second quarter of 2015 for first, second, and third shifts. c.) third quarter 2015 for second, and third shifts. Based on an interview at the time of record review, the Maintenance Director stated there was a different maintenance director during the aforementioned drill and does not know if any drills were conducted and could not provide any other documentation for review to verify drills were conducted. 3.1-19(b) 3.1-51(c)			
K 0056 SS=E Bldg. 01	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 water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are			

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	155702	A. BUILDING 01 B. WING	10/29/2015

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	electrically connected to the building fire alarm system. 19.3.5 1. Based on observation and interview, the facility failed to ensure complete automatic sprinkler system was provided for 2 of 2 window recesses in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. Exception: Sprinklers shall not be required where all of the following conditions are met: (a) the room is dedicated to electrical equipment only. (b) Only dry-type electrical equipment is used. (c) Equipment is installed in a 2-hour fire-rated enclosure including protection for penetrations. (d) No combustible storage is permitted to be stored in the room. This deficient practice could up to 10 residents in the therapy room. Findings include: Based on observation during a tour of the facility with the Maintenance Director on 10/29/15 at 11:45 a.m., two window recesses in the therapy room lacked sprinkler coverage. Each recess raised three feet into the ceiling to make space for the windows. The opening of the recesses measured two feet by six feet, and the sprinklers for the therapy room are at ceiling level below the recesses.	K 0056	Therapy window recesses requiring sprinkler installation to be installed on 11/25/2015. The Service Hall Clean Linen Cabinet System will have shelf installed to ensure compliance with distance of sprinkler heads on 11/27/2015. Maintenance performed audit of facility to ensure no other sprinklers were needed throughout the facility. SafeCare to perform inspection of facility to ensure that all needed sprinkler heads are installed properly. Findings to be given to QA Committee upon completion to ensure compliance with Life Safety Code.	11/28/2015

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	Based on an interview at the time of observation, the Maintenance Director acknowledged the lack of sprinkler coverage in the recesses and provided the measurements. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 2 of 2 sprinkler heads in the service hall clean linen cabinet system were separated by at least six feet as required by NFPA 13. NFPA 13 Section 5-6.3.4 requires sprinklers be located no closer than six feet measured on center. This deficient practice was not in a resident care area but could affect any staff in the service hall. Findings include: Based on observation during a tour of the facility with the Maintenance Director on 10/29/15 at 10:30 a.m., the service hall clean linen cabinet system had two sprinkler heads located three feet apart. Based on interview and the time of observation, the Maintenance Director acknowledged the sprinkler heads were less than three feet apart. 3.1-19(b)			

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K 0062 SS=F 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 record review and interview, the facility failed to ensure sprinkler water flow alarm devices were tested quarterly for 3 of 4 quarters. LCS 9.7.5 refers to NFPA 25, the Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, at 2-3.3 requires water flow alarm devices and pressure switches that provide audible or visual signals to be tested quarterly. This deficient practice affects all occupants. Findings include: Based on review of "Report of Inspection" sprinkler inspection documentation from Safe Care with the Maintenance Director on 10/29/15 at 10:15 a.m., the facility lacked documentation for sprinkler inspections where the water flow alarms were tested for the first, second, and third quarters of 2015. Based on an interview at the time of record review, the Maintenance Director called Safe Care for	K 0062	SafeCare performed sprinkler inspections to test the water flow alarms on 11/15/2015. Main Hall Mechanical room had missing tiles replaced on 11/27/2015. Service Hall Clean Linen room had items above the 18 inch mark removed to be in compliance on 10/30/2015. SafeCare to perform quarterly sprinkler inspections and documentation provided to QA Committee for review. Monthly inspections to be performed by maintenance or designee to ensure all ceiling tiles are intact and in place. Indicator strip to be placed in all storage areas to ensure no items are placed closer than 18 inches to sprinkler head height. Monthly audit to be performed by maintenance or designee of storages areas to ensure no items are placed within 18 inches of sprinklers. All findings of audits and quarterly inspections to be given to the QA Committee monthly for a period of 6 months or until a pattern of	11/28/2015

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	documentation of the sprinkler inspection, but the only documentation sent by Safe Care was a sprinkler inspection from 12-18-2014. The Maintenance Director could not provide any other documentation to show inspections were conducted for the last three quarters of 2015. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 1 sprinkler systems was continuously maintained in reliable operating condition. This deficient practice could affect up to 20 residents in 1 of 8 smoke compartments. Findings include: Based on observation during a tour of the facility with the Maintenance Director on 10/29/15 at 11:40 a.m., over three fourths of the ceiling tiles were missing in the mechanical room on main hall. Due to the two foot space between the sprinkler heads and the roof decking, this could delay the activation of the sprinkler system in event of a fire. Based on interview during observation, the Maintenance Director acknowledged the ceiling tiles were missing leveling the sprinkler heads two feet below the roof		substantial compliance is achieved.	

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	decking. 3.1-19(b) 3. Based on observation and interview, the facility failed to ensure the spray pattern for 3 of 12 sprinklers in the service hall clean linen cabinet system. NFPA 25, 1998 Edition Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, Section 2-2.1.2 states unacceptable obstructions to spray patterns shall be corrected. NFPA 13, 1999 Edition Standard for the Installation of Sprinkler Systems, Section 5-8.5.1.1 states sprinklers shall be located so as to minimize obstructions to discharge as defined in 5-8.5.2 and 5-8.5.3, or additional sprinklers shall be provided to ensure adequate coverage of the hazard. This deficient practice was not in a resident care area but could affect any staff in the service hall. Findings include: Based on observation during a tour of the facility with the Maintenance Director on 10/29/15 at 10:40 a.m., the spray pattern for three sprinkler heads in the service hall clean linen cabinet system were obstructed by towels stored less than 18 inches from sprinkler heads. Based on			

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	interview, the Maintenance Director acknowledged the obstructed sprinklers at the time of observation. 3.1-19(b)			
K 0064 SS=B Bldg. 01	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 1 of 28 portable fire extinguishers was given maintenance at periods not more than one year apart. NFPA 10, the Standard for Portable Fire Extinguishers, in 4-4.1 requires extinguishers shall be subjected to maintenance not more than one year apart or when specifically indicated by a monthly inspection. 4-2.2 defines maintenance as a "thorough check" of the extinguisher. It is intended to give maximum assurance the extinguisher will operate effectively and safely. This deficient practice was not in a resident care area but could affect all staff on the service hall. Findings include: Based on observation during a tour of the facility with the Maintenance Director on	K 0064	Maintenance Office fire extinguisher was discharged and taken out of service on 11/4/2015 as it was a surplus extinguisher. Maintenance to perform monthly audit of all fire extinguishers in the facility. Thompson Fire and Safety to perform required annual inspection of all fire extinguishers. Results of monthly audit and annual inspection to be given to the QA Committee for review to ensure continued compliance.	11/28/2015

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	10/29/15 at 09:07 a.m., there was no annual maintenance tag attached to the portable ABC Class fire extinguisher located in the Maintenance office. Based on interview, the Maintenance Director stated the extinguisher is a back up and was not a part of the annual inspection. 3.1-19(b)			
K 0068 SS=E Bldg. 01	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 Based on observation and interview, the facility failed to ensure 1 of 1 laundry rooms was provided with intake combustion air from the outside for rooms containing fuel fired equipment in accordance with LSC Section 19.5.2.2. This deficient practice could create an atmosphere rich with carbon monoxide which could cause physical problems for staff in the laundry room. Findings include: Based on observation during a tour of the facility with the Maintenance Director on 10/29/15 at 11:00 a.m., the laundry room had fuel fired dryers with no fresh air intake. Based on interview, this was	K 0068	Fuel fired dryers in Laundry Room to have fresh air intake installed on 11/25/2015 to ensure adequate air flow. Maintenance to perform annual inspection of fresh air intakes for the Laundry Room dryers to ensure continued compliance. Results to be given to QA Committee for review.	11/28/2015

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	acknowledged by the Maintenance Director at the time of observation. 3.1-19(b)			
K 0074 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Draperies, curtains, including cubicle curtains, and other loosely hanging fabrics and films serving as furnishings or decorations in health care occupancies are in accordance with provisions of 10.3.1 and NFPA 13, Standards for the Installation of Sprinkler Systems. Shower curtains are in accordance with NFPA 701. Newly introduced upholstered furniture within health care occupancies meets the criteria specified when tested in accordance with the methods cited in 10.3.2 (2) and 10.3.3. 19.7.5.1, NFPA 13 Newly introduced mattresses meet the criteria specified when tested in accordance with the method cited in 10.3.2 (3) , 10.3.4. 19.7.5.3 Based on observation and interview, the facility failed to ensure 1 of 1 sets of curtains located in the conference room was flame retardant. This deficient practice could affect up to 15 residents near the conference room. Findings include: Based on observations during a tour of	K 0074	Drapes covering dry erase board in the conference room were removed on 10/30/2015. Maintenance performed facility audit of draperies to ensure all draperies in facility are fire retardant. Annual inspection to be completed by maintenance for continued compliance.	11/28/2015

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	the facility with the Maintenance Director on 10/29/15 at 12:40 p.m., there was a set of curtains covering a dry erase board in the conference room. Upon inspection of the curtains, no flame retardant rating was found. Based on interview at the time of observation, the Maintenance Director indicated there was no documentation regarding flame retardants for the curtains. 3.1-19(b)		Findings of maintenance audit to be given to QA Committee for review until a pattern of substantial compliance is achieved.	
K 0104 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Penetrations of smoke barriers by ducts are protected in accordance with 8.3.6. Based on observation and interview, the facility fail to ensure 1 of 7 smoke barrier duct penetrations were provided with a working smoke damper. LSC 101 section 8.3.5.1 states an approved damper designed to resist the passage of smoke shall be provided for each air transfer opening or duct penetration of a required smoke barrier. This deficient practice could affect up to 35 residents in 2 of 8 smoke compartments. Findings include: Based on observation during a tour of the facility with the Maintenance Director on 10/29/15 at 2:00 p.m., there was a smoke damper installed in a ventilation duct that	K 0104	Smoke damper by therapy room had wire hanger removed from damper on 11/4/2015. Fusible link to be installed on 11/27/2015. Facility audit to be performed to ensure all smoke dampers have proper fusible link system. Results of audit to be given to QA Committee to ensure compliance.	11/28/2015

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	penetrated the smoke barrier wall by therapy. Upon inspection, the damper was held open with a wire hanger tied to the damper. No fusible link system was observed. Based on interview this was acknowledged by the Maintenance Director at the time of observation. 3.1-19(b)			
K 0000 Bldg. 02	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 10/29/15 Facility Number: 003130 Provider Number: 155702 AIM Number: 200386750 At this Life Safety Code survey, Aperion Care-Peru was found in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR 483.70(a) Life Safety from Fire, the 2000 edition of the NFPA (National Fire Protection Association) 101, LSC (Life Safety Code), and 410 IAC 16.2. The West Wing with 27 beds was surveyed with	K 0000	*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.*	

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	Chapter 18, New Health Care Occupancies. This one story facility was determined to be of Type II (222) 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 smoke detectors in all resident rooms. The facility has a capacity of 92 and had a census of 54 at the time of this survey. All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered. Quality Review completed 11/12/15 - DA			
K 0025 SS=E Bldg. 02	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one-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 in approved 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. 18.3.7.3, 18.3.7.5, 18.1.6.3			

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	1. Based on observation and interview, the facility failed to ensure the penetrations caused by the passage of wire and/or conduit through 1 of 1 west hall smoke barrier walls were protected to maintain the smoke resistance of each smoke barrier. LSC Section 19.3.7.3 requires smoke barriers to be constructed in accordance with LSC Section 8-3. 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. This deficient practice could affect 19 residents on the west hall. Findings include: Based on observation during a tour of the facility with the Maintenance Director on 10/29/15 at 2:20 p.m., the smoke barrier wall in the west hall had a half inch unsealed penetration around wires. Based on interview at the time of observation, the Maintenance Director provided the size of the penetration. 3.1-19(b)	K 0025	The smoke barrier penetrations cited will be repaired with approved material capable of maintaining the smoke resistance to that smoke barrier. The opening in the closet on Touchstone will be patched and repaired according to Life Safety standards. Areas in question to be repaired on November 27, 2015. Facility to audit all smoke barrier walls to ensure no penetrations or unapproved material is being used to prevent smoke transfer. Any openings or areas with unapproved material will be patched and repaired appropriately. Maintenance or designee shall perform monthly audit to ensure all smoke barriers are intact and proper material is used for penetrations. Findings will be given to the QA Committee monthly for a period of 6 months or until a pattern of substantial compliance is achieved.	11/28/2015

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	Based on observation and interview, the facility failed to ensure 1 of 1 ceiling smoke barriers were maintained to provide a one half hour fire resistance rating. LSC 8.3.2 requires smoke barriers shall be continuous from an outside wall to an outside wall. This deficient practice could affect 19 residents on the west hall. Findings Include: Based on observation during a tour of the facility with the Maintenance Director on 10/29/15 between at 11:30 a.m., in the ceiling of the west hall medication room there was a penetration sealed with gray caulk around wires. Based on interview at the time of observation, the Maintenance Director did not know if the gray caulk was an approved material and did not have the documentation to show if the caulk met the requirements for use in through penetration fire stop systems. 3.1-19(b)			
K 0029 SS=E Bldg. 02	NFPA 101 LIFE SAFETY CODE STANDARD Hazardous areas are protected in accordance with 8.4. The areas are enclosed with a one hour fire-rated barrier, with a 3/4 hour fire-rated door, without windows (in accordance with 8.4). Doors are self-closing or automatic closing in			

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	accordance with 7.2.1.8. 18.3.2.1 Based on observation and interview, the facility failed to ensure 1 of 1 corridor doors to the soiled utility room in the west hall was provided with self closing devices causing the doors to automatically close and latch into the door frame. This deficient practice could affect 19 residents in the west hall. Findings include: Based on observation during a tour of the facility with the Maintenance Director on 10/29/15 at 12:33 p.m., the soiled utility room on west hall did self close but failed to latch into the frame. The soiled utility room contained barrels of trash and hazardous waste. Based on interview, this was acknowledged by the Maintenance Director at the time of observation. 3.1-19(b)	K 0029	The dining room door cited was adjusted and repaired on 10/30/2015 to ensure compliance. All self-closing doors will be audited by maintenance department to ensure that they close and latch properly on 11/27/2015. Monthly audit to be performed by maintenance or designee to ensure all self-closing doors in the facility close and latch appropriately. Findings will be given to the QA Committee monthly for a period of 6 months or until a pattern of substantial compliance is achieved.	11/28/2015
K 0038 SS=E Bldg. 02	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. 18.2.1 Based on observation and interview, the facility failed to ensure the means of egress through 2 of 2 exits in west hall were readily accessible for residents	K 0038	The key codes to the exit doors were changed to match the mounted stickers 10/30/2015. Wooden board blocking door was removed on 10/30/2015. All additional exit doors with key	11/28/2015

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	without a clinical diagnosis requiring specialized security measures. LSC 18.2.2.2.4 requires doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side. Exception No. 1 requires door-locking arrangements without delayed egress shall be permitted in health care occupancies, or portions of health care occupancies, where the clinical needs of the residents require specialized security measures for their safety, provided staff can readily unlock such doors at all times. This deficient practice could affect 19 residents who did not require special security measures. Findings include: Based on observation during a tour of the facility with the Maintenance Director on 10/29/15 between 10:30 a.m. and 2:00 p.m., two exit doors on the west hall did not require special security measures were magnetically locked and could be opened by entering a code. The posted code on the keypad was "fiftysevenelevenstar" for all exits on west hall. When that code was inputted on the key pad, the door did not release. Based on interview at the time of observations, the Maintenance Director stated the code on the door has been		codes were checked by maintenance to ensure code mounted matched the actual code. All other exit doors checked by maintenance to ensure nothing was obstructing their egress. Key codes will be changed on the first of every month to match the month and year (4 digits). Maintenance will perform a monthly audit to ensure compliance with key code and mounted pass code changes. Maintenance to also perform monthly an audit of all exit doors for obstructions to allow proper egress. Findings will be given to the QA Committee monthly for a period of 6 months or until a pattern of substantial compliance is achieved.	

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	changed and the code posted on the key pad is an older code no longer working. 3.1-19(b)			
K 0045 SS=F Bldg. 02	NFPA 101 LIFE SAFETY CODE STANDARD Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 18.2.8 Based on interview and observation, it was determined that the facility failed to provide exterior emergency lighting for 9 of 9 exits. LSC Section 7.9.1.1 requires emergency lighting facilities for means of egress shall be provided for the exit access and exit discharge. This deficient practice could affect all occupants in the facility if the facility was required to evacuate in an emergency and the generator was providing electricity at that time. Findings include: Based on observation during a tour of the facility with the Maintenance Director on 10/29/15 between 10:00 a.m. and 2:00 p.m., it was unknown if the exterior lights for the exit discharge for all of the facility exits were connected to the generator. Based on interview at the time	K 0045	Exterior lights for exit discharge were found to be in compliance by SafeCare on 11/6/2015. No exterior lights for exit discharge were found to be non-compliant. Exterior lights for exit discharge to be checked monthly by maintenance to ensure they are functioning properly. Findings will be given to the QA Committee monthly for a period of 6 months or until a pattern of substantial compliance is achieved.	11/28/2015

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	of observation, when asked if the exterior lights were powered by the generator during power loss; the Maintenance Director stated "probably not but I do not know for sure. I will have to check with the generator company to find out." 3.1-19(b)			
K 0046 SS=F Bldg. 02	NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 18.2.9.1 1. Based on observation, records and interview; the facility failed to ensure emergency light fixtures for 1 of 1 generators were tested annually for 1½ hour duration and monthly for 30 second duration in accordance with LSC 7.9. LSC 7.9.3 Periodic Testing of Emergency Lighting Equipment requires an annual test shall be conducted on every required battery powered emergency lighting system for a minimum of 1 ½ hour duration and every required battery powered emergency lighting system at 30 day intervals for a minimum of 30 seconds. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having	K 0046	All emergency battery powered lights were tested for 90 minutes on 11/27/2015. Malfunctioning emergency battery powered light with no test button was replaced on 11/27/2015. All emergency battery powered lights in the facility will be tested monthly for 30 seconds and 90 minutes annually. Findings will be given to the QA Committee monthly for a period of 6 months or until a pattern of substantial compliance is achieved.	11/28/2015

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	jurisdiction. This deficient practice could affect all occupants. Findings include: Based on observation during a tour of the facility with the Maintenance Director on 10/29/15 at 10:30 a.m., a pair of lights powered by a battery as backup lighting for the emergency generator was observed by the generator. Based on records review with the Maintenance Director on 10/29/15 at 10:00 a.m., no documentation was available for review to show the testing of the emergency battery powered lights at the facility's generator. Based on interview at the time of record review and observation, when ask if the emergency battery powered lights are tested 30 seconds monthly and 90 minutes annually; the Maintenance Director stated the emergency battery powered lights are not tested for 30 seconds monthly or 90 minutes annually. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 1 battery powered emergency lighting fixtures at the generator would operate. LSC 7.9.2.5 requires battery operated emergency lights shall be capable of repeated automatic operation. This deficient			

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	practice could affect all occupants. Findings include: Based on observation during a tour of the facility with the Maintenance Director on 10/29/15 at 10:30 a.m., a pair of lights powered by a battery as backup lighting for the emergency generator was observed by the generator. The battery operated lights failed to illuminate because there was no test button to test the lights. Base on interview at the time of observation, the Maintenance Director tried to test the lights but could not find a way to test the lights. 3.1-19(b			
K 0050 SS=F Bldg. 02	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. 18.7.1.2 Based on record review and interview, the facility failed to ensure fire drills were conducted quarterly on each shift for 3 of the last 4 completed quarters.	K 0050	Fire drills will begin to be performed and documented on a monthly basis by the facility maintenance department or designee. Fire Drills	11/28/2015

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	This deficient practice could affect all occupants. Findings include: Based on record review of the "Fire Drill Report" with the Maintenance Director on 10/29/15 at 10:10 a.m., there were no records of fire drills for the following quarters: a.) first quarter of 2015 for first, second, and third shifts. b.) second quarter of 2015 for first, second, and third shifts. c.) third quarter 2015 for second, and third shifts. Based on an interview at the time of record review, the Maintenance Director stated there was a different maintenance director during the aforementioned drill and does not know if any drills were conducted and could not provide any other documentation for review to verify drills were conducted. 3.1-19(b) 3.1-51(c)		will consist of all three shifts per quarter being performed at random times throughout the year. Monthly fire drills will be sent to the QA Committee on a monthly basis indefinitely to ensure continued compliance.	
K 0062 SS=F Bldg. 02	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 18.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5			

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	Based on record review and interview, the facility failed to ensure sprinkler water flow alarm devices were tested quarterly for 3 of 4 quarters. LCS 9.7.5 refers to NFPA 25, the Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, at 2-3.3 requires water flow alarm devices and pressure switches that provide audible or visual signals to be tested quarterly. This deficient practice affects all occupants. Findings include: Based on review of "Report of Inspection" sprinkler inspection documentation from Safe Care with the Maintenance Director on 10/29/15 at 10:15 a.m., the facility lacked documentation for sprinkler inspections where the water flow alarms were tested for the first, second, and third quarters of 2015. Based on an interview at the time of record review, the Maintenance Director called Safe Care for documentation of the sprinkler inspection, but the only documentation sent by Safe Care was a sprinkler inspection from 12-18-2014. The Maintenance Director could not provide any other documentation to show inspections were conducted for the last three quarters of 2015.	K 0062	SafeCare performed sprinkler inspections to test the water flow alarms on 11/15/2015. Main Hall Mechanical room had missing tiles replaced on 11/27/2015. Service Hall Clean Linen room had items above the 18 inch mark removed to be in compliance on 10/30/2015. SafeCare to perform quarterly sprinkler inspections and documentation provided to QA Committee for review. Monthly inspections to be performed by maintenance or designee to ensure all ceiling tiles are intact and in place. Indicator strip to be placed in all storage areas to ensure no items are placed closer than 18 inches to sprinkler head height. Monthly audit to be performed by maintenance or designee of storages areas to ensure no items are placed within 18 inches of sprinklers. All findings of audits and quarterly inspections to be given to the QA Committee monthly for a period of 6 months or until a pattern of substantial compliance is achieved.	11/28/2015

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	3.1-19(b)			
K 0147 SS=B Bldg. 02	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 1 of 1 flexible cords such as an extension cord was not used as a substitute for fixed wiring. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 1999 Edition. NFPA 70, Article 400-8 requires 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 2 residents in room 400. Findings include: Based on observation during a tour of the facility with the Maintenance Director on 10/29/15 at 12:25 p.m., in room 400 a regular light weight extension cord was plugged in and providing power for a fan and radio. Based on interview, this was acknowledged by the Maintenance Director at the time of observations.	K 0147	Room 400 extension cord removed by maintenance on 10/30/2015. Maintenance performed facility wide audit on 11/25/2015 to ensure no other unapproved extension cords are being used. Maintenance to perform monthly audit to ensure that no unapproved extension cords are in use. Findings of monthly audit to be given to the QA Committee for a period of 6 months or until a pattern of substantial compliance is achieved.	11/28/2015

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