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	12/22/2015

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 Post Survey Revisit (PSR) to the Life Safety Code Recertification and State Licensure Survey conducted on 10/29/15 was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 12/22/15 Facility Number: 003130 Provider Number: 155702 AIM Number: 200386750 At this PSR 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	K 0000		

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	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 with exception of two window recesses in the therapy room. All areas providing facility services were sprinklered. Quality Review completed 01/04/16 - DA			
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 Based on observation and interview, the facility failed to ensure 1 of 1 sprinkler systems were 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 12/22/15 at 10:40 a.m., over three fourths of the ceiling tiles were missing in the mechanical room on main hall. Due to	K 0062	**K062** **The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.*	01/21/2016

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	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 decking. Also, the Maintenance Director stated "We are getting quotes for raising the sprinkler heads, but do not have a date when the sprinklers will be raised." This deficiency was cited on 10/29/15. The facility failed to implement a systemic plan or correction to prevent recurrence. 3.1-19(b)		*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 actions taken for those residents identified:** Safe Care was scheduled to come in on 1/21/16 to raise sprinklers to achieve coverage ceiling of Mechanical room. **2) How the facility identified other residents:** Audits of other sprinkler heads were conducted to ensure they provide maximum coverage of area. Other sprinkler heads were seen to be in compliance. **3) Measures put into place/ System changes:** Maintenance will do monthly audit of sprinkler to ensure they are of	

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			correct height and coverage. **4) How the corrective actions:** 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:** **01/21/2016**	
K 0000 Bldg. 02	A Post Survey Revisit (PSR) to the Life Safety Code Recertification and State Licensure Survey conducted on 10/29/15 was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 12/22/15	K 0000		

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	155702	A. BUILDING 02 B. WING	12/22/2015

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