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	01/03/2017

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: 01/03/17 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		

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

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	capacity of 92 and had a census of 67 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 on 01/09/17-DA			
K 0351 SS=B Bldg. 01	NFPA 101 Sprinkler System - Installation Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) Based on observation and interview, the facility failed to maintain the ceiling construction in 1 of 7 smoke	K 0351	**K 351**	01/11/2017

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	compartments. NFPA 13, 2010 edition, Section 6.2.7 states plates, escutcheons, or other devices used to cover the annular space around a sprinkler shall be metallic, or shall be listed for use around a sprinkler. This deficient practice could affect up to 22 residents, as well as staff and visitors in the 100 Hall smoke compartment. Findings include: Based on observation with the Maintenance Director on 01/03/17 at 12:15 p.m., the 100 Hall sprinkler near resident room #137 had a loose escutcheon. The gap between the escutcheon and the ceiling measured approximately three quarters of an inch. Based on interview at the time of observations, the Maintenance Director acknowledged the aforementioned condition.		**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 actions taken for those residents identified:** Facility Maintenance Director ensured escutcheons near room 137 was free of gaps between it and the ceiling. **2) How the facility identified other residents:** Maintenance Director and Safecare did a complete audit of	

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			escutcheons to determine if there are any gaps between them and the ceiling. **3) Measures put into place/ System changes:** The Maintenance Director will be responsible for oversight of these audits The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **5) Date of compliance: 1-11-17**	
K 0372 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING			

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	Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS.			
	Based on observation and interview, the facility failed to ensure the penetrations caused by the passage of wire and/or conduit through 1 of 6 smoke barrier walls were protected to maintain the smoke resistance of each smoke barrier. LSC Section 18.3.7.5 requires smoke barriers to be constructed in accordance with LSC Section 8.5 and shall have a minimum one hour fire resistive rating. This deficient practice could affect as many as 20 residents, 4 staff and 4 visitors. Findings include: Based on observations with the Maintenance Director on 01/03/17 at 12:45 p.m., a two inch diameter pipe that had several wires passing through, and a four inch diameter hole was discovered above the smoke barrier in the dining room hall near the conference room. Based on interview at the time of	K 0372	**K 372** **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 actions taken for**	01/11/2017

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	observation, the Maintenance Director acknowledged the aforementioned condition and provided the measurement for the penetrations. 3.1-19(b)		**those residents identified:** Facility Maintenance Director used intumescent caulk to fill hole in smoke barriers. **2) How the facility identified other residents:** Maintenance Director did an audit of facility smoke barriers to identify any holes in smoke barriers. **3) Measures put into place/ System changes:** Monthly inspections will be done to smoke barriers to ensure that they are free of holes, Smoke barriers will also be inspected after each vendor visit to ensure that they did not leave any holes in smoke barriers. Maintenance Director will be responsible for oversight of these audits. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved. The QA Committee will	

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			identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **5) Date of compliance: 1-11-17**	