STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155277	A. BUILDING 01 B. WING	09/27/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE VALPARAISO	3301 N CALUMET AVE VALPARAISO, IN 46383

(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 08/17/17 was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 09/27/17 Facility Number: 000176 Provider Number: 155277 AIM Number: 100288940 At this PSR survey, Aperion Care Valparaiso was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This facility is located in two, two story buildings with walk out lower levels and connected by the "tunnel", a one story corridor. The two buildings, identified as the Pines and the Manor were determined to be of Type II (111) construction, built prior to March 1, 2003 and fully	K 0000	**The facility request 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 for 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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	sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in all areas open to the corridor. The facility has battery operated smoke detectors in resident sleeping Rooms #1 through #37 on the Pines upper level and hard wired smoke detectors supervised by the fire alarm system in rooms 38 through 43 on the Pines lower level. Smoke detectors in resident sleeping rooms on the upper and lower level are hard wired. The facility has the capacity for 150 and had a census of 86 at the time of this visit. All areas where the residents have customary access were sprinklered and all areas providing facility services were sprinklered. Quality Review completed on 09/28/17 - DA			
K 0311 SS=E Bldg. 01	NFPA 101 Vertical Openings - Enclosure Vertical Openings - Enclosure 2012 EXISTING Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least 1 hour. An atrium may be used in accordance with 8.6. 19.3.1.1 through 19.3.1.6 If all vertical openings are properly enclosed with construction providing at least a 2-hour fire resistance rating, also check this			

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	box. Based on observation and interview, the facility failed to maintain protection of 2 of 4 stairways in accordance of 19.3.1. LSC 19.3.1.1 requires where an enclosure is provided, the construction shall have not less than a 1-hour fire resistance rating. This deficient practice could affect staff and at least 48 residents. Findings include: Based on observation with the Maintenance Director on 08/17/17 at 11:16 a.m., the following was discovered; a) the Manor Lower south stairwell contained a three inch by five inch penetration above the drop ceiling. Additionally the penetration confirmed that only one piece of five eighths inch drywall was installed making the stairwell a half an hour construction b) the Manor Center stairwell did not continue all the way to the roof decking Based on interview at the time of each observation, the Maintenance Director confirmed that none of the stairwell repairs had been performed yet. 3.1-19(b) This deficiency was cited on 08/17/17. The facility failed to implement a systemic plan of correction to prevent	K 0311	**K311** **The facility request 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 for 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 take for those residents identified:** **No residents were identified in this citation.** **2. How the facility identified other residents:** **All residents on Manor had the potential to be affected by this alleged deficient practice.**	09/28/2017

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	recurrence.		**3. Measures put into place/ System changes:** **Manor Lower south stairwell and Manor Center stairwell penetrations were repaired on 9/28/2017 and an additional layer of five eighths drywall was applied to meet the 1-hour fire resistant guideline.** **4. How the corrective actions will be monitored:** **The results of these audits if necessary will be reviewed by the Quality Assurance Committee monthly for 90 days, or until 100% compliance is achieved.** **5. Date of compliance: 9/28/2017**	
K 0372 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to			

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	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 2 of 6 smoke barrier walls were protected to maintain the smoke resistance of each smoke barrier. LSC Section 19.3.7.5 requires smoke barriers to be constructed in accordance with LSC Section 8.5 and shall have a minimum ½ hour fire resistive rating. This deficient practice could affect staff and at least 69 residents. Findings include: Based on observations with the Maintenance Director on 09/27/17 at 11:19 a.m., the following unsealed penetrations were discovered: a) a one inch penetration and a two inch penetration above the ceiling tile in the Manor Rehab Dining room smoke barrier. Additionally, a two and a half inch by two and a half inch penetration around sprinkler pipe above the ceiling tile b) a two inch by two inch and a three	K 0372	**K372** **The facility request 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 for 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 take for those residents identified:** **No residents were identified in this citation.** **2. How the facility identified other residents:** **All staff and residents within the**	09/28/2017

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	inch by three inch penetration above the ceiling tile in the resident room 266 smoke barrier Based on interview at the time of each observation, the Maintenance Director confirmed that none of the repairs has been completed. 3.1-19(b) This deficiency was cited on 08/17/17. The facility failed to implement a systemic plan of correction to prevent recurrence.		**facility have the potential to be affected by this alleged deficient practice.** **3. Measures put into place/ System changes:** **1. a) one inch penetration and a two inch penetration above the ceiling tile in the Manor Rehab Dining room smoke barrier along with the two and a half by two and a half inch penetration around the sprinkler pipe above the ceiling tile were repaired as of 9/28/2017 with fire rated ASTM-814 fire rated caulk** **b) two inch by two inch and a three inch by three inch penetration above the ceiling tile in the resident room 266 smoke barrier was repaired as of 9/28/2017 and caulked with fire rated ASTM-814 fire caulk.** **4. How the corrective actions will be monitored:** **The results of these audits if necessary will be reviewed by the Quality Assurance Committee**	

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			monthly for 90 days, or until 100% compliance is achieved. **5. Date of compliance: 9/28/2017**	
K 0522 SS=D Bldg. 01	NFPA 101 HVAC - Any Heating Device HVAC - Any Heating Device Any heating device, other than a central heating plant, is designed and installed so combustible materials cannot be ignited by device, and has a safety feature to stop fuel and shut down equipment if there is excessive temperature or ignition failure. If fuel fired, the device also: * is chimney or vent connected * takes air for combustion from outside * provides for a combustion system separate from occupied area atmosphere 18.5.2.2, 19.5.2.2 Based on observation and interview, the facility failed to ensure 1 of 1 Laundry room was provided with intake combustion air from the outside for rooms containing fuel fired equipment. This deficient practice could affect staff only. Findings include: Based on observation with the Maintenance Director on 09/27/17 at 11:16 a.m., the laundry room had fuel-fired dryers. Based on interview at	K 0522	**K522** **The facility request 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 for the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is**	09/28/2017

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	the time of observation, the Maintenance Director was unable to locate the fresh air intake source. 3.1-19(b) This deficiency was cited on 08/17/17. The facility failed to implement a systemic plan of correction to prevent recurrence.		**required by the provisions of federal and state law.** **1. Immediate actions take for those residents identified:** **No residents were identified in this citation.** **2. How the facility identified other residents:** **All staff within the facility have the potential to be affected by this alleged deficient practice.** **3. Measures put into place/ System changes:** **Maintenance Director or designee identified the fresh air intake source within the facility laundry room on 9/28/2017 and label it accordingly.** **4. How the corrective actions will be monitored:** **The results of these audits if necessary will be reviewed by the Quality Assurance Committee monthly for 90 days, or until 100% compliance is achieved.**	

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