STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155572	A. BUILDING -- B. WING	12/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
APERION CARE DEMOTTE	10352 N 600 E COUNTY LINE RD DEMOTTE, IN 46310

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
E 0000 Bldg. --	An Emergency Preparedness Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 12/12/22 Facility Number: 000471 Provider Number: 155572 AIM Number: 100290390 At this Emergency Preparedness survey, Aperion Care - Demotte was found in substantial compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR Subpart 483.73. The facility is certified for 93 dual certified beds. At the time of the survey, the census was 80. Quality Review completed on 12/14/22	E 0000		
E 0004 SS=C Bldg. --	403.748(a), 416.54(a), 418.113(a), 441.184(a), 482.15(a), 483.475(a), 483.73(a), 484.102(a), 485.625(a), 485.68(a), 485.727(a), 485.920(a), 486.360(a), 491.12(a), 494.62(a) Develop EP Plan, Review and Update Annually §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a).			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Kelly DeYoung	HFA	12/28/2022

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155572	A. BUILDING -- B. WING	12/12/2022

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	The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. .			
	Based on record review and interview, the facility	E 0004	**E 004**	12/25/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155572	A. BUILDING -- B. WING	12/12/2022

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APERION CARE DEMOTTE	10352 N 600 E COUNTY LINE RD DEMOTTE, IN 46310

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	failed to develop and maintain an emergency preparedness plan that was reviewed and updated at least annually in accordance with 42 CFR 483.73(a). This deficient practice could affect all occupants. Findings include: Based on review of the facility's Emergency Preparedness Plan on 12/12/22 between 9:30 a.m. to 10:02 a.m. with the Maintenance Director present, documentation for an updated emergency preparedness program reviewed by the facility within the most recent twelve-month period was not available for review. The emergency plan available had not been reviewed within the past twelve-months with the last documented date of review having not been documented in the plan. Based on interview at the time of record review, the Maintenance Director stated that he was unaware of the requirement for an annual update on the plan. During the exit conference with the facility Administrator and the Maintenance Director at 2:05 p.m., no additional information or evidence could be provided contrary to this deficient finding.		The facility requests desk review 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:** **The Emergency Preparedness Plan was reviewed and updated immediately in accordance with 42 CFR 483.73(a).** **2) How the facility identified other residents:** **All residents may be affected by this deficient practice.** **3) Measures put into place/ System changes:**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
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			The HFA/Executive Director will ensure that the Emergency Preparedness Plan is updated annually. **4) How the corrective actions will be monitored:** **The HFA/Executive Director will ensure that the Emergency Preparedness Plan is reviewed and updated annually. An audit will be performed yearly to ensure compliance.** **The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 100% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.** **5) Date of compliance: 12-25-22**	
E 0013 SS=C Bldg. --	403.748(b), 416.54(b), 418.113(b), 441.184(b), 482.15(b), 483.475(b), 483.73(b), 484.102(b), 485.625(b), 485.68(b), 485.727(b), 485.920(b), 486.360(b),			

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	155572	A. BUILDING -- B. WING	12/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	491.12(b), 494.62(b) Development of EP Policies and Procedures §403.748(b), §416.54(b), §418.113(b), §441.184(b), §460.84(b), §482.15(b), §483.73(b), §483.475(b), §484.102(b), §485.68(b), §485.625(b), §485.727(b), §485.920(b), §486.360(b), §491.12(b), §494.62(b). (b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(b):] Policies and procedures. The LTC facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. *Additional Requirements for PACE and ESRD Facilities: *[For PACE at §460.84(b):] Policies and procedures. The PACE organization must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at			

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	155572	A. BUILDING -- B. WING	12/12/2022

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	paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must address management of medical and nonmedical emergencies, including, but not limited to: Fire; equipment, power, or water failure; care-related emergencies; and natural disasters likely to threaten the health or safety of the participants, staff, or the public. The policies and procedures must be reviewed and updated at least every 2 years. *[For ESRD Facilities at §494.62(b):] Policies and procedures. The dialysis facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. These emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic area.			
	Based on record review and interview, the facility failed to update and implement emergency preparedness policies and procedures. The policies and procedures must be reviewed and updated at least annually in accordance with 42 CFR 483.73(b). This deficient practice could affect all residents in the facility. Findings include: Based on review of the facility's Emergency Preparedness Plan on 12/12/22 between 9:30 a.m.	E 0013	**E 0013** The facility requests desk review 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*	12/25/2022

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	to 10:02 a.m. with the Maintenance Director present, documentation for an updated policies and procedures reviewed by the facility within the most recent twelve-month period was not available for review. The emergency plan available had not been reviewed within the past 12 months with the last documented date of review having not been documented in the plan. Based on interview at the time of record review, the Maintenance Director stated that he was unaware of the requirement for an annual update on the plan. During the exit conference with the facility Administrator and the Maintenance Director at 2:05 p.m., no additional information or evidence could be provided contrary to this deficient finding.		*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:** **The Emergency Preparedness Plan was reviewed and updated immediately in accordance with 42 CFR 483.73(a).** **2) How the facility identified other residents:** **All residents may be affected by this deficient practice.** **3) Measures put into place/ System changes:** **The HFA/Executive Director will ensure that the Emergency Preparedness Plan is updated annually.** **4) How the corrective actions will be monitored:**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
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			The HFA/Executive Director will ensure that the Emergency Preparedness Plan is reviewed and updated annually. An audit will be performed yearly to ensure compliance. **The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 100% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.** **5) Date of compliance: 12-25-22**	
E 0029 SS=C Bldg. --	403.748(c), 416.54(c), 418.113(c), 441.184(c), 482.15(c), 483.475(c), 483.73(c), 484.102(c), 485.625(c), 485.68(c), 485.727(c), 485.920(c), 486.360(c), 491.12(c), 494.62(c) Development of Communication Plan §403.748(c), §416.54(c), §418.113(c), §441.184(c), §460.84(c), §482.15(c), §483.73(c), §483.475(c), §484.102(c), §485.68(c), §485.625(c), §485.727(c), §485.920(c), §486.360(c), §491.12(c), §494.62(c). (c) The [facility] must develop and maintain an emergency preparedness communication			

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	155572	A. BUILDING -- B. WING	12/12/2022

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	plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. Based on record review and interview, the facility failed to develop and maintain an emergency preparedness communication plan that complies with Federal, State, and local laws in accordance with 42 CFR 483.73(c). This deficient practice could affect all occupants. Findings include: Based on review of the facility's Emergency Preparedness Plan on 12/12/22 between 9:30 a.m. to 10:02 a.m. with the Maintenance Director present, documentation for an updated communication plan reviewed by the facility within the most recent twelve-month period was not available for review. The emergency plan available had not been reviewed within the past 12 months with the last documented date of review having not been documented in the plan. Based on interview at the time of record review, the Maintenance Director stated that he was unaware of the requirement for an annual update on the plan. During the exit conference with the facility Administrator and the Maintenance Director at 2:05 p.m., no additional information or evidence could be provided contrary to this deficient finding.	E 0029	**E 0029** The facility requests desk review 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:** **The Emergency Preparedness Plan was reviewed and updated immediately in accordance with 42 CFR 483.73(a).** **2) How the facility identified other residents:** **All residents may be affected by this deficient practice.**	12/25/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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			3) Measures put into place/ System changes: **The HFA/Executive Director will ensure that the Emergency Preparedness Plan is updated annually.** **4) How the corrective actions will be monitored:** **The HFA/Executive Director will ensure that the Emergency Preparedness Plan is reviewed and updated annually. An audit will be performed yearly to ensure compliance.** **The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 100% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.** **5) Date of compliance: 12-25-22**	

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E 0036 SS=C Bldg. --	403.748(d), 416.54(d), 418.113(d), 441.184(d), 482.15(d), 483.475(d), 483.73(d), 484.102(d), 485.625(d), 485.68(d), 485.727(d), 485.920(d), 486.360(d), 491.12(d), 494.62(d) EP Training and Testing §403.748(d), §416.54(d), §418.113(d), §441.184(d), §460.84(d), §482.15(d), §483.73(d), §483.475(d), §484.102(d), §485.68(d), §485.625(d), §485.727(d), §485.920(d), §486.360(d), §491.12(d), §494.62(d). *[For RNCHIs at §403.748, ASCs at §416.54, Hospice at §418.113, PRTFs at §441.184, PACE at §460.84, Hospitals at §482.15, HHAs at §484.102, CORFs at §485.68, CAHs at §486.625, "Organizations" under 485.727, CMHCs at §485.920, OPOs at §486.360, and RHC/FHQs at §491.12:] (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(d):] (d) Training and testing. The LTC facility must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the			

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	communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. *[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(i). *[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be evaluated and updated at every 2 years.			
	Based on record review and interview, the facility failed to develop and maintain an emergency preparedness training and testing program that was reviewed and updated at least annually in accordance with 42 CFR 483.73(d). This deficient practice could affect all occupants.	E 0036	**E 0036** The facility requests desk review for this citation. *This Plan of Correction is the center's credible allegation of*	12/25/2022

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	Findings include: Based on review of the facility's Emergency Preparedness Plan on 12/12/22 between 9:30 a.m. to 10:02 a.m. with the Maintenance Director present, documentation for an updated training and testing program reviewed by the facility within the most recent twelve-month period was not available for review. The emergency plan available had not been reviewed within the past 12 months with the last documented date of review having not been documented in the plan. Based on interview at the time of record review, the Maintenance Director stated that he was unaware of the requirement for an annual update on the plan. During the exit conference with the facility Administrator and the Maintenance Director at 2:05 p.m., no additional information or evidence could be provided contrary to this deficient finding.		*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:** **The Emergency Preparedness Plan was reviewed and updated immediately in accordance with 42 CFR 483.73(a).** **2) How the facility identified other residents:** **All residents may be affected by this deficient practice.** **3) Measures put into place/ System changes:** **The HFA/Executive Director will ensure that the Emergency Preparedness Plan is updated annually.**	

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			4) How the corrective actions will be monitored: **The HFA/Executive Director will ensure that the Emergency Preparedness Plan is reviewed and updated annually. An audit will be performed yearly to ensure compliance.** **The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 100% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.** **5) Date of compliance:** **12-25-22**	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 12/12/22	K 0000		

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	155572	A. BUILDING 01 B. WING	12/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
APERION CARE DEMOTTE	10352 N 600 E COUNTY LINE RD DEMOTTE, IN 46310

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	Facility Number: 000471 Provider Number: 155572 AIM Number: 100290390 At this Life Safety Code survey, Aperion Care - Demotte 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 one-story facility was determined to be of Type V (111) 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 detectors in all resident sleeping rooms. The facility has a capacity of 93 and had a census of 80 at the time of this survey. All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered except for one detached P.O.D. for storage and one detached generator shed which provided facility storage and were not sprinklered. Quality Review completed on 12/14/22			
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system			

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	option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322)			
	Based on observation and interview, the facility failed to ensure 1 of 5 hazardous areas, such as a House Keeping/Bio-hazard room or a storage room of combustible supplies over 50 square feet in size, was provided with a self-closing door or device which would cause the door to automatically close and latch into the door frame. This deficient practice could affect as many as 20 residents, 4 staff, and 2 visitors in the facility. Findings include: Based on observations made during a tour of the facility with the Maintenance Director on 12/12/22	K 0321	**K- 321** The facility requests desk review 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*	12/25/2022

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	the following was noted: a) At 1:05 p.m. the area identified as the "Cubby", a room that measured approximately 20 feet wide by 24 feet long and open to the corridor was packed full of well over 100 boxes of cardboard and miscellaneous building and remodeling supplies creating a hazardous area. b) At 1:09 p.m. the area identified as a second Lobby, an area that measured approximately 30 feet long by 25 feet wide and open to the corridor was packed full of well over 150 boxes of cardboard and miscellaneous building and remodeling supplies creating a hazardous area. It was noted that both of these areas did not have doors and therefore could not be enclosed or separated to protect the corridor as an emergency path of egress. Based on interview at the time of the observations, the Maintenance Director stated there was nowhere else in the facility to store these items, but he would discuss the issue with the Administrator. During the exit conference with the facility Administrator and the Maintenance Director at 2:05 p.m., no additional information or evidence could be provided contrary to this deficient finding. 3.1-19(b)		*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:** **All cardboard boxes and miscellaneous building and remodeling supplies were removed on 12-13-22 and placed in an enclosed area.** **2) How the facility identified other residents:** **All residents may be affected by this deficient practice.** **3) Measures put into place/ System changes:** **Maintenance Director In-Serviced regarding proper storage procedures. Contractors notified of facility storage guidelines.** **4) How the corrective actions will be monitored:** **HFA/Maintenance Director will**	

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			perform daily audits to ensure all remodel materials are stored properly in enclosed areas. **HFA/Maintenance Director to also ensure all other material is properly stored in enclosed areas.** **Audits will be performed times 6 months.** **The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 100% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.** **5) Date of compliance:** **12-25-22**	
K 0351 SS=E 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			

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	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 5 corridors in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. NFPA 13, 2010 edition, Section 6.2.7.1 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 as many as 20 residents, 4 staff and 2 visitors within the smoke compartment. Findings include: Based on observation with the Maintenance Director on 12/12/22 at 12:52 p.m., the corridor sprinkler head near the West Nurses station had a missing escutcheon. Based on interview at the time of observation, the Maintenance Director acknowledged the missing escutcheon and advised that he would have his vendor replace the escutcheon the next time they were in the building to inspect the sprinkler system. During the exit conference with the facility Administrator and the Maintenance Director at 2:05 p.m., no additional information or evidence could be provided contrary to this deficient finding. 3.1-19(b)	K 0351	**K- 351** The facility requests desk review 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:** **Notified Valley Fire Protection Systems immediately. Missing Escutcheon will be replaced on 12-28-22 .**	12/28/2022

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			2) How the facility identified other residents: **All residents may be affected by this deficient practice** **3) Measures put into place/ System changes:** **Maintenance Director /Assistant was In-Serviced regarding observation of missing Escutcheon.** **4) How the corrective actions will be monitored:** **Maintenance Director/Designee will perform weekly audits to assure all Escutcheons are properly installed at all times for 6 months.** **The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 100% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.**	

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			5) Date of compliance: **12-28-22**	
K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on record review and interview, the facility failed to provide written documentation or other evidence the sprinkler system components had been inspected and tested for 1 of 4 quarters. LSC 4.6.12.1 requires any device, equipment or system required for compliance with this Code be maintained in accordance with applicable NFPA requirements. Sprinkler systems shall be properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 4.3.1 requires records shall be made for all inspections, tests, and maintenance of the system components and shall be made available to the	K 0353	**K- 353** The facility requests desk review 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*	12/25/2022

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	authority having jurisdiction upon request. 4.3.2 requires that records shall indicate the procedure performed (e.g., inspection, test, or maintenance), the organization that performed the work, the results, and the date. NFPA 25, 5.2.5 requires that waterflow alarm devices shall be inspected quarterly to verify they are free of physical damage. NFPA 25, 5.3.3.1 requires the mechanical waterflow alarm devices including, but not limited to, water motor gongs, shall be tested quarterly. 5.3.3.2 requires vane-type and pressure switch-type waterflow alarm devices shall be tested semiannually. This deficient practice could affect all residents, staff, and visitors in the facility. Findings include: Based on record review of the quarterly sprinkler system inspection records on 1212/22 at 9:52 a.m. with the Maintenance Director present, there was no quarterly sprinkler system inspection report available for the first quarter (January, February, and March) of 2022. During an interview at the time of record review, the Maintenance Director called his vendor and was told that the previous Maintenance Director called them on January 1st of 2022 and told them they would no longer be providing sprinkler system inspections for the facility. During the exit conference with the facility Administrator and the Maintenance Director at 2:05 p.m., no additional information or evidence could be provided contrary to this deficient finding. 3.1-19(b)		*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 contacted to obtain missing documentation for the first quarter. Documents were not able to be obtained for the first quarter due to prior Director error. Contacted Valley Fire to ensure inspections are scheduled for the next year.** **2) How the facility identified other residents:** **All residents may be affected by this deficient practice** **3) Measures put into place/ System changes:** **Maintenance Director In-Serviced regarding Automatic Sprinkler Standpipe Systems are inspected, tested, and maintained in accordance NFPA 25. Sprinkler Inspections confirmed with Valley Fire for**	

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			following year . **4) How the corrective actions will be monitored:** **HFA will perform quarterly audits to ensure Sprinkler System components have been inspected per NFPA 25 standards.** **The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 100 % compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.** **5) Date of compliance:** **12-25-22**	
K 0511 SS=C Bldg. 01	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2			

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	Based on observation and interview the facility failed to ensure that the emergency generator had a reliable source of fuel in accordance with the requirements of NFPA 101 - 2012 edition, Section 19.5.1.1, 9.1, 9.1.3.1 and NFPA 110, 2010 Edition, 5.1. LSC section 9.1.3.1 states emergency generators shall be installed, tested, and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, 2010 Edition. Section 5.1.1 states the following energy sources shall be permitted to be used for the emergency power supply (EPS): (1) Liquid petroleum products at atmospheric pressure (2) Liquefied petroleum gas (liquid or vapor withdrawal) (3) Natural or synthetic gas Exception: For Level 1 installations in locations where the probability of interruption of off-site fuel supplies is high, on-site storage of an alternate energy source sufficient to allow full output of the EPSS to be delivered for the class specified shall be required, with the provision for automatic transfer from the primary energy source to the alternate energy source. A.5.1.1 states examples of probability of interruption could include the following: earthquake, flood damage, or a demonstrated utility unreliability. This deficient practice had the potential to affect all residents, visitors, and staff within the facility. Findings include: Based on observation made with the Maintenance Director at 11:48 a.m. on 12/12/22, the fuel source for the emergency generator was verified as to be natural gas. Additionally, based on interview, the facility did not have a letter from their natural gas provider indicating the natural gas was from a	K 0511	**K 511** The facility requests desk review 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:** **The HFA contacted NIPSCO (The facilities natural gas supplier) immediately requesting a letter stating that the facilities natural gas was provided from a reliable source.** **2) How the facility identified other residents:** **All residents, visitors and staff may be affected by this**	12/25/2022

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	reliable source. The lack of this letter stating that the fuel source for the emergency generator was from a reliable source was acknowledged by the Maintenance Director at the time of the observation. During the exit conference with the facility Administrator and the Maintenance Director at 2:05 p.m., no additional information or evidence could be provided contrary to this deficient finding. 3.1-19(b)		**deficient practice** **3) Measures put into place/ System changes:** **The HFA will ensure that the letter from NIPSCO stating the facility has a reliable gas source complying with NFPA 54, National Fuel Gas code is always available in the emergency preparedness manual.** **4) How the corrective actions will be monitored:** **The HFA /Executive Director will ensure that Emergency Preparedness Plan is reviewed and updated annually to ensure compliance. An audit will be performed yearly to ensure compliance.** **The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.**	

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			5) Date of compliance: 12/25/22	
K 0920 SS=E Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 Based on observation and interview, the facility failed to ensure 1 of 2 lounge areas where flexible cords were not used as a substitute for fixed wiring. LSC 9.1.2 requires electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code. NFPA 70, 2011 Edition, Article 400.8 requires that, unless specifically permitted, flexible cords and cables shall not be	K 0920	**K-920** The facility requests desk review for this citation. *This Plan of Correction is the center's credible allegation of compliance.*	12/25/2022

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	used as a substitute for fixed wiring of a structure. This deficient practice could affect as many as 20 residents, 4 staff and 2 visitors within the smoke compartment. Findings include: Based on observation with the Maintenance Director on 12/12/22 at 12:59 p.m., a power strip was found to be in use in the Room #106 Lounge area and had a microwave oven and a small refrigerator plugged into it. Upon seeing the power strip, the Maintenance Director removed the power strip from use and plugged both the microwave oven and the small refrigerator directly into a wall socket removing the deficiency. Although this deficiency was removed prior to my exiting of the facility, it still was reviewed with the Administrator at the exit conference on 12/22/22 at 2:05 p.m. 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:** **Maintenance Director removed the power strip form use immediately.** **2) How the facility identified other residents:** **All residents may be affected by this deficient practice** **3) Measures put into place/ System changes:** **A facility wide audit was performed to ensure proper UL Listed Power Strips with fault protection are being used in the facility. All improper power strips will be removed from facility and replaced with UL 60601-1 Power Strips with fault Protection.**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155572	A. BUILDING 01 B. WING	12/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
APERION CARE DEMOTTE	10352 N 600 E COUNTY LINE RD DEMOTTE, IN 46310

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
			An All-Staff In-Service was performed on 12-14-22 regarding proper power strip usage. **4) How the corrective actions will be monitored:** **Maintenance / Designee will perform weekly audits to assure proper power strips are being used in facility in accordance with NFPA . times 6 months .** **The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 100% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.** **5) Date of compliance: 12-25-22**	